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VOLUME 14 SEPTEMBER-OCTOBER, 1954 NUMBER 1

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ENDOCRINE AND METABOLIC RESPONSES TO STRESS
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(1) Kirby, W. M. M.; Waddington, W. S., & Doornink, G. M.: Antibiotics Annual, 1953-1954, New York, Medical Encyclopedia, Inc., 1953, p. 285.
(2) Finland, M., & Haight, T. H.: *Arch. Int. Med.* **91**:143, 1953.

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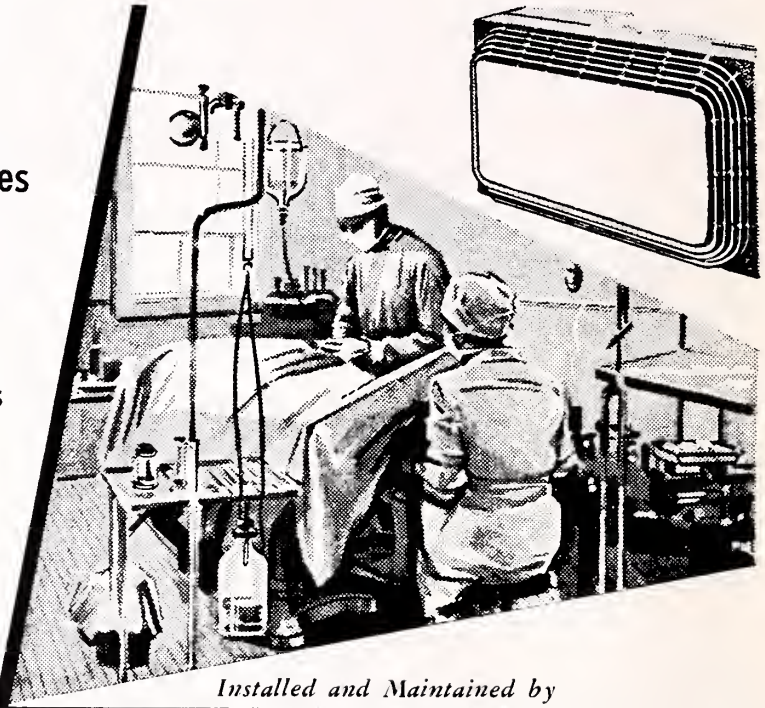
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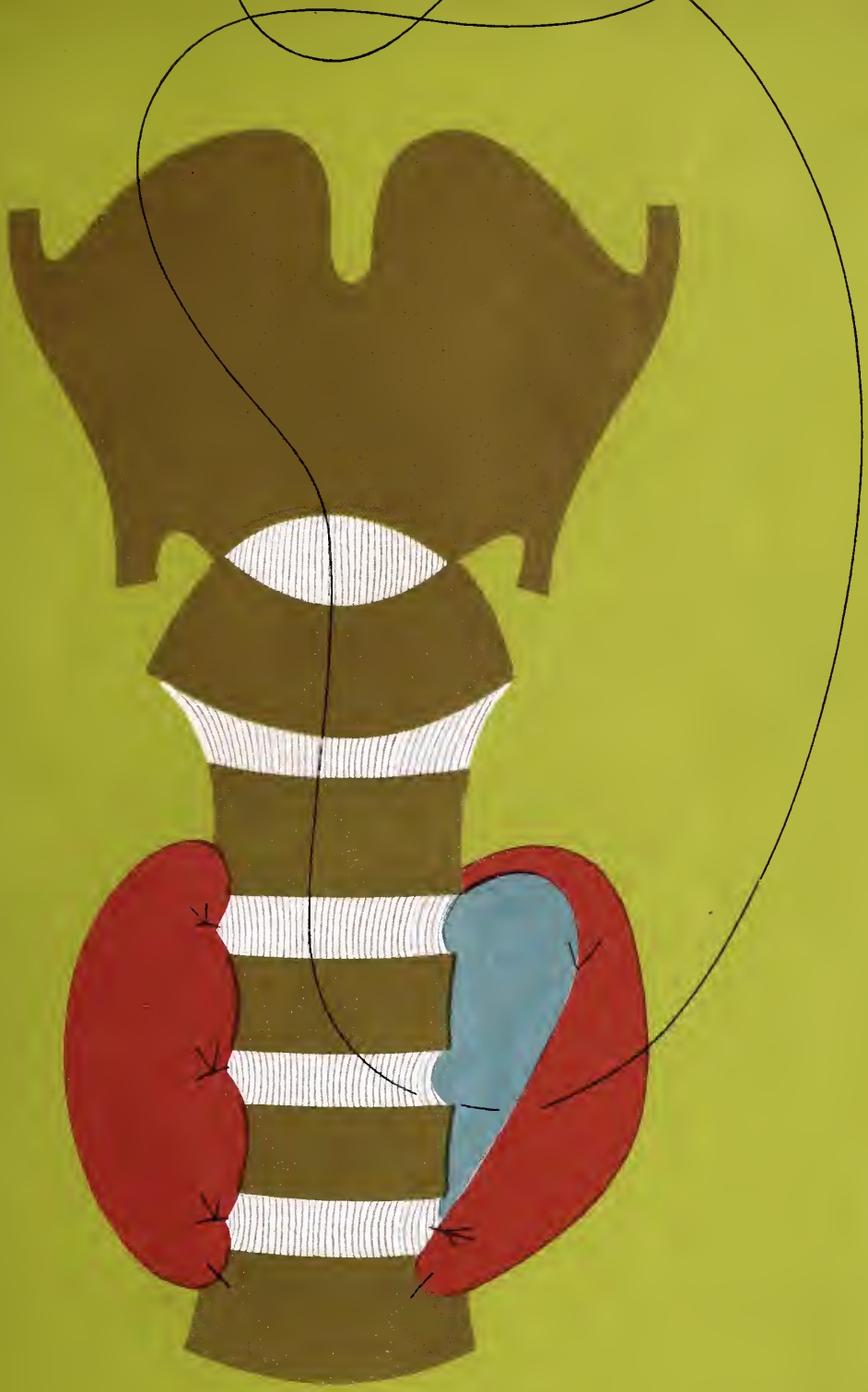


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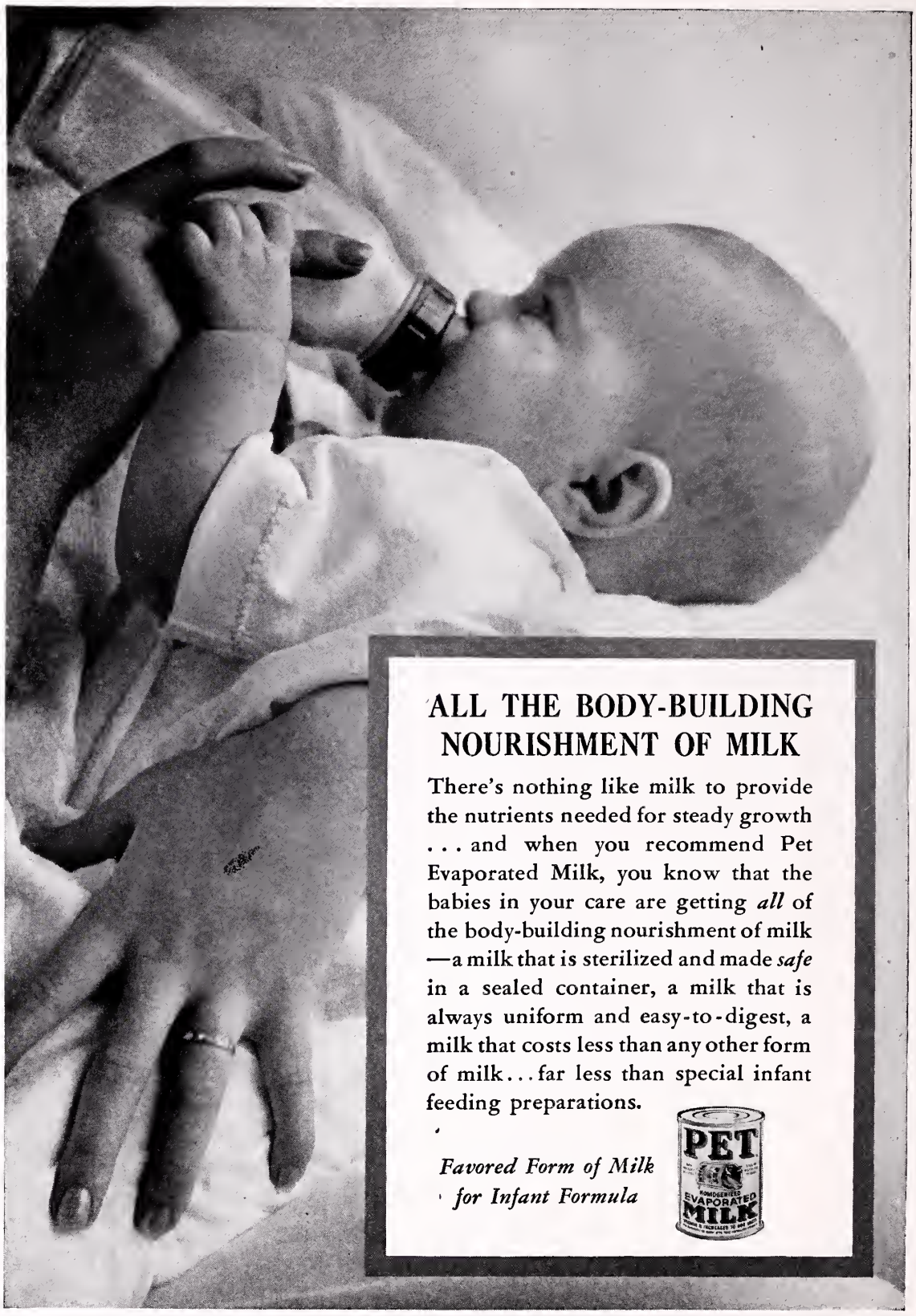
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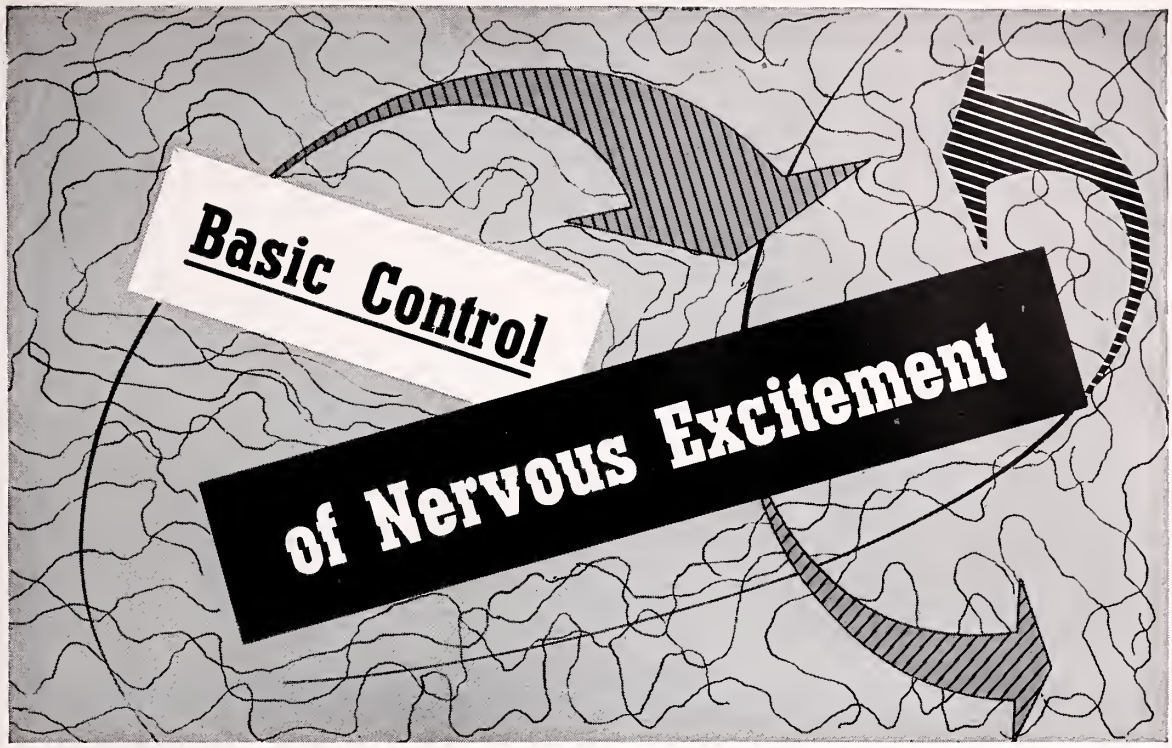
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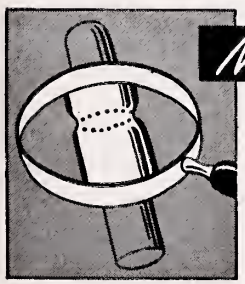
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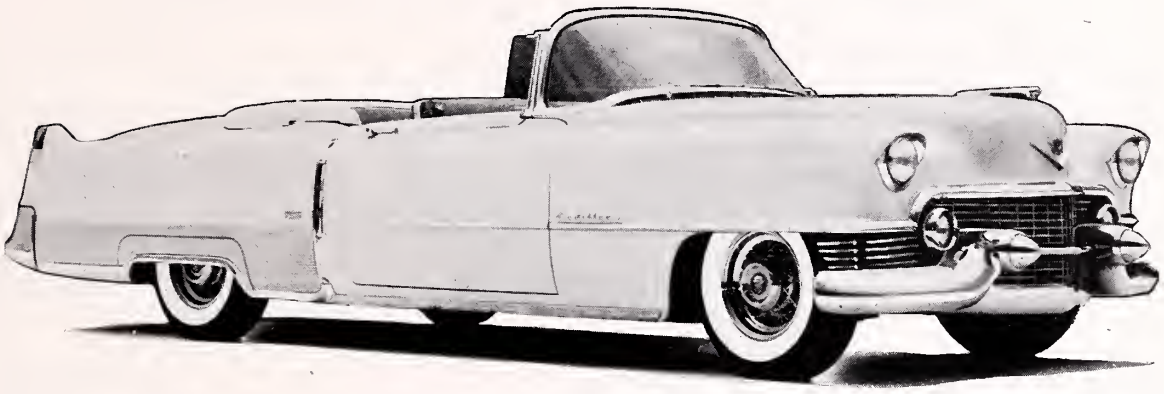
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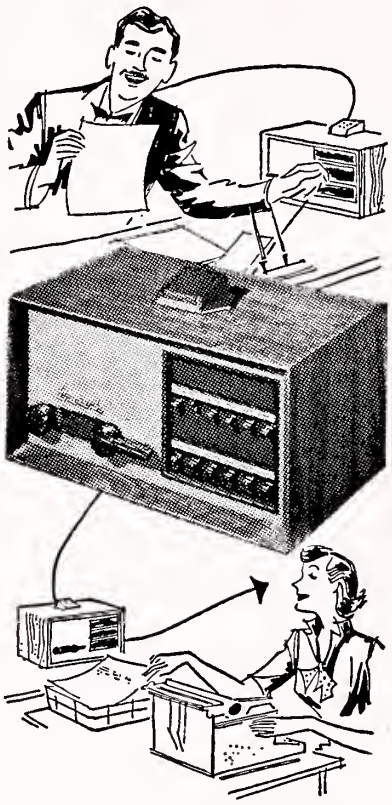


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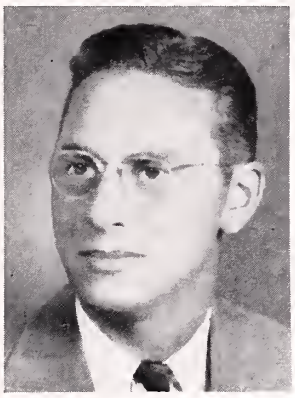


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MAN'S ENDOCRINE AND METABOLIC RESPONSES TO STRESSING CIRCUMSTANCES: CLINICAL IMPLICATIONS

JEROME W. CONN, M.D., Ann Arbor*

THE subject of our discussion, "Man's response to stressing circumstances," contains a tremendous number of ramifications, each of which has far-reaching importance. Man has been able to adapt himself to life anywhere on this globe — in the heat, in the cold; in the dry and in the wet; in sunlight and in darkness. Upon exposure to invading organisms he mobilizes defenses which sometimes represent permanent barriers to those offenders in the future. Within certain tolerability limits, he has a remarkable capacity to recover from physical injury. The great majority of humans make a satisfactory adjustment to acute or chronic mental anguish. These are but a few examples of the vast area encompassed by the phrase "man's response to stress."



DR. CONN

From the time of our birth, we come out fighting; aware of it or not, we fight for survival until we take our last and final breath. This is a vague and cumbersome definition of stress and counter-stress, but it cannot be defined simply. It is simply a concept, with which one can eventually feel at ease. It is being realized that man's total internal response to a change in his environment is one which allows him to cope with the new situation. A man accustomed to a temperate climate, when suddenly exposed to a tropical one, finds himself unable to perform physical work. He develops fever and certain mental symptoms occur. After ten to fourteen days, however, adjustments have taken place which allow him to perform almost as well as people native to that area. While such facts have been known, it has been in only recent years that we have begun to learn the mechanisms which are activated to bring about such purposeful adjustments. I wish in this short period of time to touch only the high points. My purpose is to make you aware of the broad biological implications of these mechanisms.

Historical Background

Let us start from the beginning with Selye's initial experiments in 1937. Some of you are aware of the papers that have emanated from the laboratory of Hans Selye in Montreal, beginning as I said in 1937 and coming up to the present time. Some of the papers are excellent, and bring out concepts of greatest importance.

From a historical point of view, it is interesting to look back and realize how Selye accidentally discovered a very important biological phenomenon. He thought that there should be a hormone in the ovaries that did things that none of the other known hormones could do, and so he started to look for this hypothetical ovarian hormone. He ground up rat ovaries and began to inject these crude extracts into rats. What he was looking for didn't occur, but he did find that the rats that had received this crude ovarian extract developed large, hypertrophic adrenal glands, and so he thought for a while that he had discovered something else of a hormonal nature that the ovary makes. It wasn't the one he was looking for, but this material seemed to cause hyperplasia of the adrenal glands. He started to purify these extracts, but the purer he got them, the less hypertrophy of the adrenal glands he got. And so he was rather puzzled.

It occurred to him, after having repeated these experiments, that maybe it wasn't a hormone at all; perhaps it was the fact that these crude extracts were making the animals sick, for they all were sick. So he made up a similar extract of muscle, and he was able to produce the same kind of illness and the same kind of hyperplasia of the adrenals of animals, regardless of what tissue was used for the extract. That led him to believe that when he made the animal ill, for some reason or other the adrenals became hyperplastic; and that was the beginning of his important discovery.

* Professor of Medicine, Division of Endocrinology and Metabolism, University of Michigan Medical School, Ann Arbor, Michigan.

Transcribed from a tape recording of an extemporaneous address before the 98th Annual Meeting of the Hawaii Medical Association in Honolulu, May 14, 1954.

The concept then arose that any type of alarming stimulus or noxious stimulation resulted in increased adrenal cortical activity. He tested this hypothesis by using all kinds of injurious substances. For example, an injection of formaldehyde under the skin of a rat produces a very severe illness. If the amount of the formaldehyde is sufficiently high, the animal dies of shock. If it's lowered, the animal becomes very ill, but recovers, and in the course of this illness and recovery, the adrenals become very large. Then he tried other methods of injury and found that all led to adrenal hyperplasia. It didn't matter what the harmful stimulus was, the adrenal response was always the same.

Now in addition to hyperplasia of the adrenals, under conditions of harmful stimulation to an animal, there were some other anatomical things that occurred. In addition to the enlargement of the adrenals, the thymus quickly became atrophic. It lost all the thymocytes, all the lymphocytes, just as if a shot of x-ray had been given to the thymus. In a period of ten hours, most of the lymphocytes of the thymus were gone. Lymphatic structures elsewhere also lost their lymphocytes, so that there was marked diminution in the amount of lymphatic tissue throughout the body—the lymph glands, the spleen and also the circulating lymphocytes—and these things were discovered by Selye before 1940. Those were the major anatomical changes: the enlargement of the adrenals and loss of lymphatic tissues throughout the body.

The Alarm Reaction

He then did some work to find out about this enlargement of the adrenal. What was it doing, and why? So he set up an experiment in which a certain sublethal stimulus was given, for example, formaldehyde, just enough so the animal would recover. That is, he dropped the dose to a level at which most of the animals could just barely survive this very noxious stimulation. All of those animals went into shock, first, but the doses were so fixed that he knew that most would come out of it.

During the shock phase, there was metabolic evidence of decreased adrenal cortical function: that is, the metabolism was very similar in many respects to that in acute adrenal cortical insufficiency, or Addison's disease. The blood pressure fell, the blood volume decreased, there was increased sodium in the urine and decreased potassium, etc. Then, as the animal went from what he called the *shock phase* of the alarm reaction into the *countershock* phase of the alarm reaction, all these things came back to normal or went above baseline values—blood pressure, for example. The blood sugar, which in the shock phase had dropped to hypoglycemic levels, now became hyperglycemic. He thus showed that in the shock phase, in a normal animal, the amount of adrenal cortical material that was being made was not sufficient to prevent shock in the face of trauma; but that then the adrenals came to the animal's rescue and poured out excessive amounts of adrenal cortical material (as indicated by the rise in the blood sugar and blood volume, etc.) so that there was a temporary period of increased adrenal cortical activity, such as one might observe in Cushing's syndrome.

Now these observations were very early, before we had ACTH and cortisone, and they are very nicely described in these early papers. They indicated that there was a shock and a countershock phase, and that the countershock phase, which allowed survival, was mediated by increased adrenal cortical activity as shown by adrenal cortical hyperplasia.

To be certain that it was the adrenals that allowed survival from the sublethal stimulus, he did the same experiments on adrenalectomized animals. He took out the adrenal glands, and then he applied the same stimulus which most normal animals could survive; and when that stimulus was given all of the animals went into the shock phase and died. There was no countershock phase in the absence of the adrenal gland, nor was there any lymphoid loss. These animals died with normal size thymuses, and with normal amounts of lymphatic tissue in their bodies.

Having gone that far, his next group of experiments were designed in this way. He reasoned that if both adrenals became hyperplastic and hyperfunctioning as the result of a stress, then something must have told those adrenals to get big, because two adrenal glands, one on either side of the body, can't get big independently. The only common stimulus that was known was that the pituitary can make ACTH. Although ACTH has become available as a crystalline medicine in recent years, physiologists have known of the existence of ACTH in the pituitary gland for many years; and they have known that it controls the secretory activity of the normal adrenals. He reasoned that, as a result of injury, the message goes to the pituitary first; the pituitary must then make ACTH to make both of those adrenals get big. And so the next experiment was to take a group of hypophysectomized animals with the adrenals intact and apply the stimulus to them, and they too all went into the shock phase and died without ever getting into the countershock phase. And so

he proved—and this is going very rapidly over a whole lot of work that took years and I am not giving you all of the details but simply the highlights—that the pituitary-adrenal mechanism must be intact in order for an animal to survive a shocking stimulus. That, to me, is one of the most important discoveries in biology for centuries. And we now know how important it is in man.

Now these phenomena of shock and countershock, which together make up the so-called alarm reaction, occur in man, and have been proven by better means than Selye had at his disposal when he was working with animals. They happen every day, and those of you who are surgeons are well aware of this phenomenon. Every time a man has an operation his pituitary-adrenal system is activated. That can be shown by an increase in 17-ketosteroids and 17-hydroxycorticoids (compound F) in the urine. The eosinophils drop to zero, the circulating lymphocytes fall off sharply, and all of the evidence that is needed is present, to show that this mechanism is activated for three to five days after every major surgical procedure. But what's more important is that, if this mechanism does *not* work properly, that patient may die in shock postoperatively.

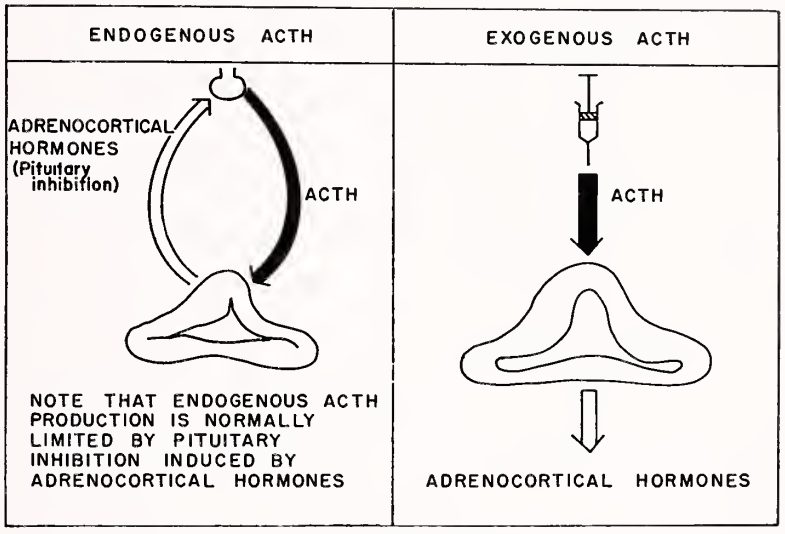


FIG. 1—Circumvention by exogenous ACTH of the mechanism normally protecting the adrenal cortex from excessive stimulation.

And so everyone who has been interested in this problem has been looking for proper means of determining, preoperatively, whether a given patient's pituitary-adrenal axis is intact and functioning normally. I say that, knowing that some of you have read of and used Thorn's epinephrine test, which was designed to trip off the pituitary-adrenal mechanism; but it doesn't work. The epinephrine test is of no value as an indicator of pituitary-adrenal responsiveness preoperatively. Dr. Thorn is one of the first to agree to that now.

When ACTH and cortisone came along, we began to recognize that certain metabolic changes occur when you give a shot of ACTH. I will make a sharp distinction between the injection of ACTH into a normal man, an unstressed man, and having his own pituitary make ACTH under conditions of stress; and I will try to indicate what the differences may be.

The Pituitary-Adrenal Response

The anterior lobe of the pituitary makes a group of protein hormones, and the one that we are interested in, in this particular discussion, is that which is called ACTH. It has but one known function: to stimulate the adrenals. ACTH in the absence of the adrenal glands does nothing, but in the presence of the adrenal glands produces very intense metabolic effects which result mainly from the secretion by the adrenals of compound F (hydrocortisone), compound B (corticosterone) and a new steroid called electrocortin (aldosterone).

Normally ACTH stimulates the adrenal cortex to secrete and to be anatomically normal. When the pituitary is removed, the adrenals become atrophic. When one gives ACTH to such an animal, the adrenals grow up again from the atrophic state to the normal, or can be made bigger than normal by giving more than the normal amount of ACTH. Figure 1 brings to your attention an important homeostatic regulatory mechanism. If we are going to be speaking about the pituitary-adrenal mechanism, we must know how it works and what things may affect it. ACTH stimulates the adrenal glands, and the adrenal glands put out steroids into the blood stream. The level of blood steroid, particularly hydrocortisone, is what determines how much ACTH is going to come out. If there is too much steroid in the blood, it inhibits the production of ACTH, to bring the blood level down. If there is too little hydrocortisone in the blood, more ACTH is made to raise the blood level; and it is within very narrow limits, by this mechanism, that the blood level for the adrenal steroids is kept reasonably constant. When one injects ACTH, he bypasses this protective mechanism. He injects ACTH; adrenal steroids get high in the blood;

they shut off endogenous ACTH which normally is a protector; but when one keeps on giving exogenous ACTH, it produces excessive adrenal cortical activity even though endogenous ACTH has been completely suppressed.

Now what is the effect of such suppression in the face of stress? We know the importance of activation of the pituitary-adrenal axis under stress. When we stop ACTH, endogenous ACTH is not being made, so the adrenal is now not getting a stimulation either from the outside or from the inside. The urinary ketosteroid level drops below normal, and may drop to the Addisonian range, indicating that the pituitary-adrenal system is now not working. After cessation of ACTH, it is usually between the fifth and the seventh day that the pituitary bounces back and stimulates the adrenals. But during that period of five to seven days, if something should come along like an acute appendicitis or a broken femur, the pituitary-adrenal system is not ready to take care of that person properly, and he may go into shock. He may die, unless one realizes that he is in shock because he sustained a stressing injury and he is temporarily hypophysectomized as far as ACTH is concerned.

Fortunately, the depression of the pituitary-adrenal axis after ACTH is short. But after cortisone, we're dealing with a more prolonged depression of the system. Cortisone is a very commonly used drug now, mainly because it can be given by mouth instead of by injection as is required with ACTH. When the blood level of cortisone rises, it shuts off endogenous ACTH. Now the adrenal (Fig. 2) is not getting any ACTH from its own pituitary, and none from us, because we are giving cortisone; so the adrenal becomes atrophic just as it would were the pituitary removed. The 17-ketosteroids fall off, because cortisone contributes very little to the 17-ketosteroids; and this indicates that the gland is depressed.

Now, when we stop the cortisone, we are dealing with very low levels of adrenal activity. The pituitary is depressed and the adrenal is either completely or partially atrophic. If one gives cortisone for two months or longer, the average duration of this depression is six weeks. But it may go for six months or a year. So it becomes very important to watch post-cortisone patients who develop shock-like symptoms after relatively minor traumatic experiences. So much for the influence of these new drugs upon the pituitary-adrenal system, with particular respect to the stress phenomena.

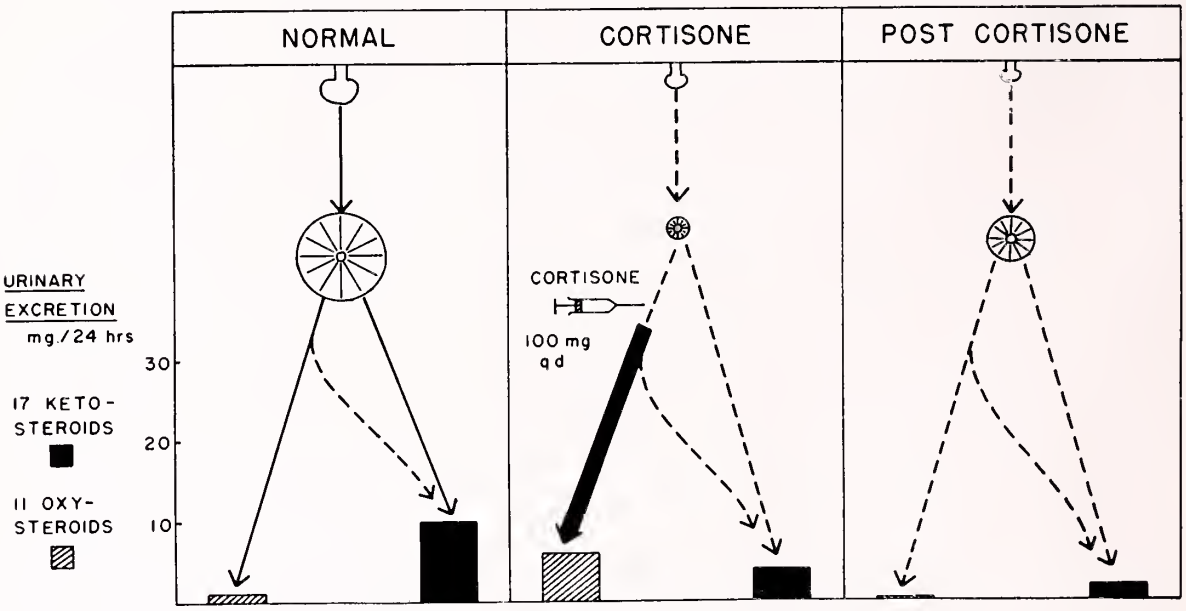


FIG. 2—Effect of cortisone on pituitary-adrenal system.

The Hypothalamus

Now we may go one step further. The anterior pituitary makes ACTH, which stimulates the adrenal cortex, which puts out adrenal cortical hormones. What people have been looking for, however, is what makes the pituitary respond to stress. From what or where does the pituitary get its stimulus? How does the pituitary know that it's supposed to make more ACTH under stress?

Well, this inquiry has been pushed a little bit further, in animals. Epinephrine from the adrenal medulla comes out rapidly under stress, and it's

known that epinephrine stimulates a center in the hypothalamus which releases a humoral substance. This stimulus from the hypothalamus to the anterior pituitary is not neural, but humoral. A material is released which specifically stimulates ACTH production and activates the system. Thus lesions in the hypothalamus may inhibit activity of this whole system.

Epinephrine is not the only thing that can stimulate the hypothalamus to secrete this substance. As a matter of fact, epinephrine does not, in man, set off the pituitary-adrenal response as we know it does in animals. Nobody has been able to show an increase in 17-ketosteroid excretion in the urine from the injection of epinephrine in man. One can show increased adrenal secretion in animals from epinephrine; but even in animals, a completely sympathectomized animal, which has no capacity to make epinephrine, still responds to an alarming stimulus by activating this mechanism in another way. So there are probably many chemical substances in the body which, like histamine, can activate this mechanism.

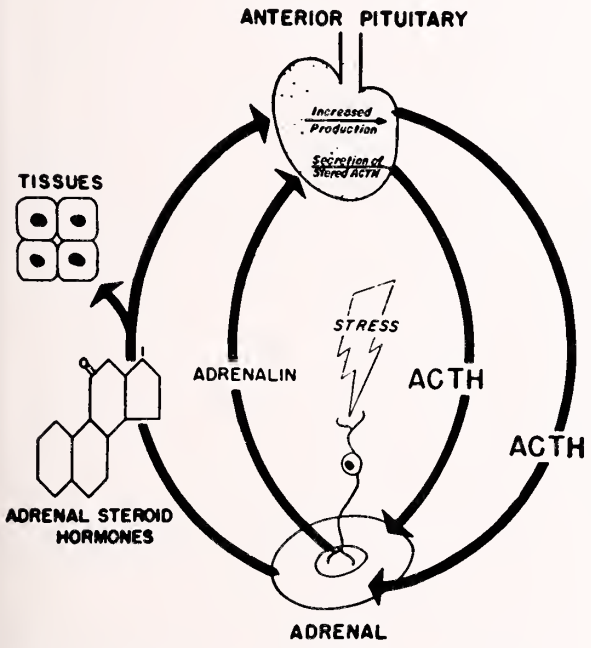


FIG. 3—Diagram illustrating the pituitary-adrenal interrelationships.

Now Figure 3 is made up on the basis of epinephrine, because we don't know what the other chemical mediators are at the moment. Stressful circumstances of many types send through the vegetative nervous system a stimulus which gets initially to the adrenal medulla. We know that the adrenal medulla is activated under conditions of acute stress: Cannon showed that many years ago in the cat. Epinephrine then, at least in animals mediated via the hypothalamus, causes a quick release of ACTH; and ACTH then stimulates the adrenal to make steroids of the compound F type.

Blood Steroid Levels

Compound F becomes highly concentrated in the adrenal venous blood under conditions of stress. Ths tissues require it; but exactly what goes on inside of the cells—what makes compound F protect man against stress—is not known. If this mechanism were known we would have greater insight into why compound F and cortisone help arthritis. This is still the 64 dollar question. I believe that when the mechanism is known by which hydrocortisone is protective under conditions of stress, we will have found the key for an explanation of the astonishing effects that we observe when we administer this substance in a wide variety of clinical diseases.

In any case, this high concentration of steroids that's coming out in the adrenal venous blood is maintained high by a continuously high level of pituitary activity under stress (inner circle—Fig. 3).

But another mechanism (the outer circle—Fig. 3) may also be operative under many circumstances. If hydrocortisone is utilized or destroyed by the tissues faster than it can be poured into the blood by the adrenals, the systemic level of blood hydrocortisone may sink below normal. This low level acts as a stimulus for increased production of ACTH. Thus a cycle is set up which goes round and round until the tissues have satisfied their requirements for adrenal steroids for that particular stressing circumstance. Then they stop using it at that rate. The general systemic blood level then rises, marking the termination of that particular stress reaction. It may be but two hours or it may be ten days that such a cycle keeps going to supply the necessary amount of adrenal steroid.

I'm sure that this diagram (Fig. 3) will prove in the future not to be correct in every detail, but it's something that can help us to think about what may be going on in many of our sick patients. You can be certain that every sick person has activated this system if it is functioning normally. Having emphasized the importance of the ACTH-adrenal system in the stress-reaction, as I should, I wish to interject now, and elaborate later, that I believe this system represents but one facet of a very complex mechanism called forth by man in response to the state of stress.

With respect to the ACTH-adrenal system, specifically, I would like to give a couple of examples of the diverse ways in which this kind of information can help us understand things that were difficult to understand before. We've talked already about surgery as inducing a stress reaction. If the reaction to stress is not activated properly, and we fail to get increased adrenal steroid in the blood, and thus fail to get a drop in the eosinophils of the peripheral blood in a newly operated-upon patient within just a few hours after operation, we know that the patient needs adrenal steroids and he needs them fast. It is possible, however, to have a good eosinopenic response and still have an insufficient adrenal response. This is because a relatively small increase in steroid level of blood will drop the eosinophils sharply.

The Thymico-lymphatic Constitution

With presently established knowledge of the "alarm reaction" one can interpret in a reasonable way what the so-called thymicolymphatic constitution and "thymic death" represent. Mention of these terms usually evokes from the physician a tolerant smile, but I believe the time has come for correlation of old information and newer knowledge. Pathologists have told us in the past that when a child is brought to the autopsy table, with a history that after a relatively minor traumatic experience the child went into a shock-like state and died, certain anatomical characteristics are likely to be found. With such a history he could often predict that the thymus would be too big; that there would be too much lymphocytic tissue throughout the body; and that the adrenal cortices would be too small. He just knew that from experience. He didn't know what the mechanism was. There are a couple of other things that were talked about, a "droplet" heart and a thin aorta, but from our point of view a large amount of lymphatic tissue and small adrenals are very important.

Now think of this set of circumstances in terms of the stress-reaction which we have been discussing. Here is a child that receives an injury that most normal people can survive, only she did not survive it. When we realize that her adrenal glands are hypoplastic and that the excessive amounts of lymphatic tissue reflect insufficiency of adrenal steroids, it becomes clearer that this sudden death was due to an imperfect response to stressing circumstances.

I mentioned earlier that under stress, the thymus involutes very rapidly, and that the lymphatic tissue diminishes rapidly. One can produce such changes in a rat by injecting cortisone. The pathologists have known that patients with Addison's disease, for example, where there is an insufficiency of adrenal steroids, have too much lymphatic tissues in their bodies. They have also told us for years that patients with adrenal cancers, of the type which produce Cushing's syndrome, have too little lymphatic tissue in their bodies. They knew that there was a reciprocal relationship between adrenal function and the amount of lymphatic tissue present. The so-called thymic death is not due to a large thymus! Nobody has ever demonstrated that the "thymic death" is due to suffocation—to compression of the trachea by an enlarged thymus—but that's been the implication. What these children die of is acute adrenal cortical insufficiency: acute Addison's disease: shock. The large amount of lymphatic tissue throughout the body is simply an indicator that there hasn't been enough adrenal steroid present to depress it to a normal degree.

What do we do when we want to do a tonsillectomy or some kind of surgical procedure on a child in whom we suspect the thymus is too big? We give some x-ray therapy over the thymus. Why do we do that when we know that they don't die of suffocation? Because we haven't known what else to do! What we should do is to prevent adrenal cortical insufficiency. We don't know, in the thymicolymphatic, whether the trouble is that they are not making enough ACTH, or that the adrenals don't respond to it. That isn't known; and whenever it isn't known, the best thing is to give the steroid. Don't give ACTH and hope that the adrenal is able to make the cortisone. As long as we have the cortisone, let's give the thing that we know they need. Cortisone will diminish the lymphatic tissues and also protect against the stress of an operative procedure. This, then, represents another example of the helpfulness of this newer knowledge.

Foreign Protein Shock Therapy

Let us take a final example that has no relation to the last one. We have learned empirically that cortisone does an excellent job of relieving acute nonspecific iritis. If you ask any good ophthalmologist, "What did you use for acute iritis before cortisone came along?" he will say, "I used intravenous typhoid vaccine." And he also says, "If I got a febrile response from it, I got a good result on the iritis; and if I didn't get a good febrile response, I didn't get much effect on the iritis."

Now, what was that? It was an alarm reaction. He gave the patient typhoid vaccine, and the patient reacted to the stress and made his

cortisone himself and helped the iritis. We have found in our own laboratory that intravenous typhoid vaccine causes a good rise in urinary excretion of 17-hydroxycorticoids. So we were using adrenal steroid therapy before we ever had cortisone, but we didn't know we were using it.

Defensive Aspects of the ACTH Effect

The metabolic changes which occur as a result of the institution of stress are extremely complex and in the light of present knowledge are difficult to interpret. One must attempt to separate what happens to a man who develops his own defense against stress from those things known to occur when an unstressed man receives injections of ACTH—if we are to understand eventually what really goes on. One of the major things that happens, when ACTH is given to a normal unstressed man, is that he begins to break down body protein. He goes into negative nitrogen balance, as shown in Figure 4. He may break down 35, 50 or more grams of body protein in a day.

Now, why should he do that? One of the concepts has been that when a man is injured he breaks down protein from the good parts of his body in an attempt to bring amino acids to the injured part for repair. Whether or not this is the right answer is unknown. As I shall indicate later, however, not all stressful stimuli evoke negative nitrogen balance.

Well, another thing we see very frequently is sugar in the urine. Why is peripheral utilization of sugar depressed? Why does he have a diabetic curve? Can there be anything useful in changing from normal carbohydrate metabolism to decreased carbohydrate consumption when one is under stress? It's possible! One of the first things that happens when one gives ACTH or cortisone is an increase in liver glycogen. The longer one keeps glycogen in the liver by depressing its peripheral utilization, the longer will the liver be capable of carrying out its normal functions.

What about the retention of sodium and chloride? Can one speculate that this is purposeful? Perhaps! Sodium and chloride are major elements in the extra cellular fluid needed to maintain blood volume. If under conditions of injury our kidneys don't stop putting out sodium and chloride we will be unable to maintain extra cellular fluid volume for as long.

I feel sure that most of the reactions that occur under conditions of stress must be purposeful ones. Some of them are duplicated when one gives ACTH to an unstressed man. Let us consider the problem of salt retention during the first few days after major surgery.

Salt Retention After Surgery

It has been known by surgeons for years that after major surgery, one must not give the patient much physiological saline for two or three days. Such a patient tends to become edematous, while an unstressed person can be given twice as much intravenous sodium chloride and he doesn't become edematous. It was said, therefore, that a postoperative patient has an "avidity" for sodium and chloride in the first two or three days. Because the alarm reaction goes on for three, four or five days after operation, we reasoned that the "avidity" for sodium chloride was due to adrenal production of a salt-retaining factor having an activity like that of desoxycorticosterone (DOCA).

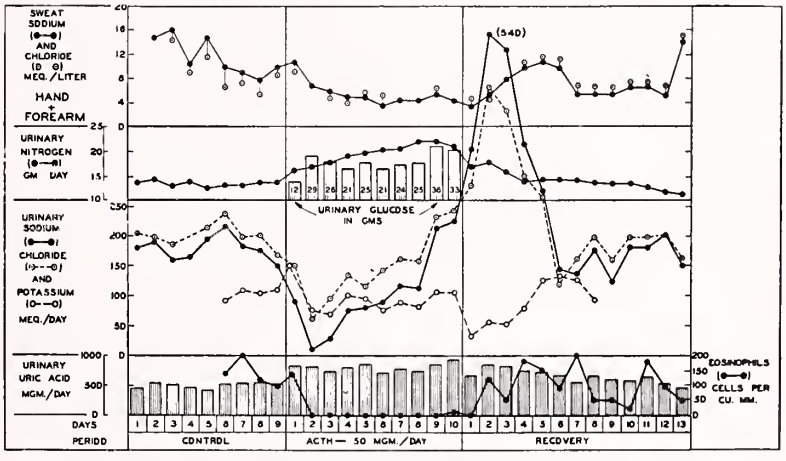


FIG. 4—Effect of ACTH on sweat Na and Cl in relation to urinary Na, K, Cl, N, glucose, uric acid, and eosinophils (R. S., male, 37, normal subject).

Now it happens that when our experiments were done there weren't any methods for determining salt-retaining factors in the urine. So we looked for an indirect method, and found that if one followed the sodium and chloride concentrations of sweat samples, one had an index of such activity. We had shown that injection of either desoxycorticosterone or ACTH would produce a sharp fall in sweat sodium and chloride. We therefore carried out analyses of serial samples of sweat obtained before operation and during the postoperative period.

In the postoperative period the characteristic changes in the chemical composition of sweat samples were as follows:

(1) A fall in the concentration of both sodium and chloride, reaching the lowest values between the fourth and sixth postoperative days and then rising gradually to baseline values.

(2) An increase in the concentration of potassium and nitrogen during the first two post-

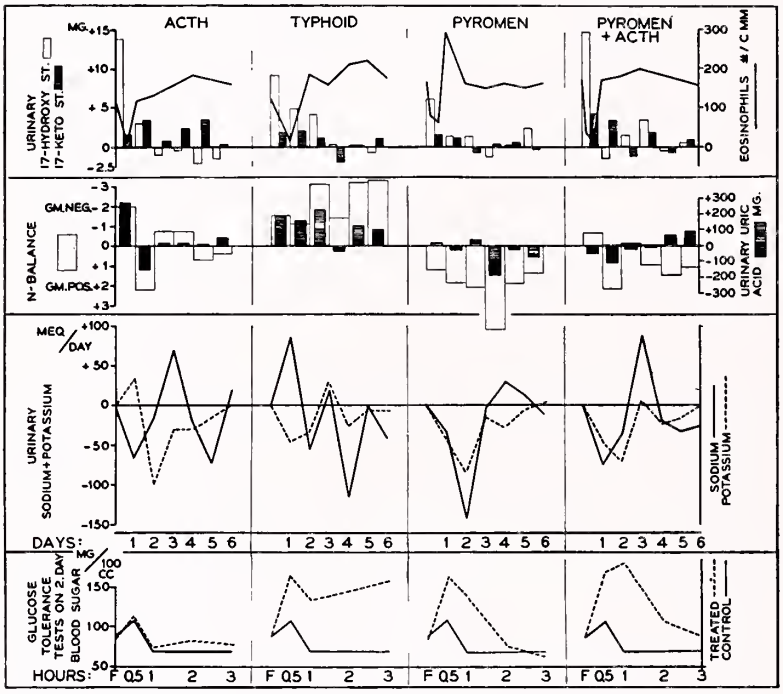


FIG. 5—Metabolic changes induced in normal man by ACTH, typhoid H antigen, Piromen, and Piromen plus ACTH.

operative days and then a gradual return to normal.

There is little question, then, that in response to the stress of surgery the adrenal secretes increased amounts of a salt-retaining hormone which accounts for the "avidity" of the body of the postoperative patient for sodium chloride.

Specific Responses to Specific Stresses

I have intimated earlier that man's total metabolic response to stress is a very complex one and that all of the mechanisms involved are not yet understood. I have emphasized the importance of the pituitary-adrenal system because we know that it is activated in the reaction to stress. On the other hand, we feel certain that either other mechanisms are activated simultaneously, or else the quality, intensity and chronicity of the noxious stimulus is a determining factor in what the total metabolic response will be when the adrenals are activated. We suspect that these two possibilities are not mutually exclusive.

Figure 5 gives an example of why we believe that important mechanisms other than, and in addition to, increased adrenal function are involved in man's total response to stressing experiences. To attempt to interpret these data in detail is beyond the scope of this presentation—and I believe that we have insufficient knowledge to interpret them adequately, anyway. Suffice it to say that when an individual is exposed to two different kinds of stressing condition (typhoid antigen versus Piromen) his total metabolic response is not the same for both; this, despite the fact that the pituitary-adrenal system has been activated in each instance. Furthermore, when the same individual (unstressed) is given a small amount of ACTH intravenously, the metabolic response, though classical, is different from either of the patterns observed during and after the application of stressing stimuli.

We believe that one of the major functions of increased circulating steroids in the stress reaction is not merely to produce the well known metabolic effects of cortisone, but to make it possible for certain other things to go on. It *permits* fundamentally independent processes to be activated quickly. We think that a certain type of noxious stimulus always brings forth a certain type of response on the part of the body with respect to that particular type of injury, and that the increased amount of adrenal steroid allows that specific response to occur. Perhaps too much emphasis has been placed upon the known metabolic effects of cortisone in relation to the total metabolic consequences of stress in man. Thank you!

BONE TRAUMA AND DELIRIUM TREMENS

J. ROBERT JACOBSON, M.D., Honolulu

DELIRIUM is a distinctive, usually transient, disturbance of the personality. As a rule it is reversible. Alcohol is only one of the toxic agents which bring it about: some others are cardiac decompensation, hepatitis and uremia. Diabetes, thyroid dysfunction, pellagra, other avitaminoses, pernicious anemia and eclampsia may be the somatic disturbances related to the delirium. The infectious conditions such as pneumonia, typhoid fever, influenza and meningitis may be etiologically responsible. Organic changes such as cerebral arteriosclerosis, senile dementia, cerebral neoplasm and trauma may be the background of a delirium.



DR. JACOBSON

The brain differs from all other organs of the body in having a duplex aspect of function. On the one hand it represents movement and glandular activity, which is purely physiological, and on the other hand it involves a person who experiences a mental aspect.

The presence of encephalopathy does not necessarily include a delirium. Clinically, there may be convulsions, paralysis, aphasia, memory loss without delirium. On the other hand the only evidence of encephalopathy may be the delirium. The alcoholic delirium has its distinctive pattern.

What is the relation between the amount of encephalopathy, the duration of encephalopathy and the kind of encephalopathy to the development of the personality disturbance? A patient may have syphilitic meningoencephalitis for a number of years without showing any symptoms.

Abstinence has been considered by some as an important feature in the development of delirium tremens, but this is very questionable. Thirty years ago Bleuler[1] discussed this question and concluded that abstinence was not the cause, but rather the result of the alcoholic illness. He pointed out that thousands of patients were admitted to sanitaria and institutions of various kinds and that rarely did delirium tremens develop in this setting of withdrawal of the drug. Piker[2] in a study in 1937 pointed out that 75 to 90 percent of alcoholic patients develop delirium tremens while drinking. He emphasized that in the remainder the cessation of drinking is the result of the alcoholic illness and not a cause.

Bowman[3] in an article in 1939 emphasizes the same point that abstinence is not a causative factor.

It has long been recognized that physical illness may be a precipitating factor in the development of delirium tremens in the alcoholic. This is unquestionably true. Cardiac decompensation, hepatitis, uremia, diabetes, thyroid dysfunction, and infectious diseases such as pneumonia, typhoid fever and influenza are all given as physical illnesses which may precipitate a delirium of a nonspecific nature in the non alcoholic and also delirium tremens in the alcoholic. In such cases the clinician has a very difficult problem of differentiation. Is he dealing with a case of delirium tremens due primarily to the alcoholic toxin or is he dealing with a non-specific type of delirium?

What precipitates the acute mental symptoms in a patient suffering from alcoholic encephalopathy? What determines the clinical manifestations of this encephalopathy in the form of convulsions, paralysis, memory loss without delirium? What determines the precipitation of delirium tremens? How much encephalopathy may be present without any symptoms whatsoever? How long can encephalopathy continue without any clinical symptoms?

My own interest in this problem was pointed up by a series of cases in which somatic illness, more especially bone fracture, was a central feature in the development of delirium tremens.

Case Reports

CASE 1.—This was a man of 55 who had drunk large amounts of wine all of his life. It in no way interfered with his work. He was never hospitalized for drinking. He was a type of "normal heavy" drinker, if we may use this term. His drinking did not interfere with his social or economic adjustment. While crossing the street he was struck by a car and suffered a fracture of the right tibia.

Three days after his admission to the hospital he developed a delirium characterized by visual and auditory hallucinations. Because of his excitement in response to his hallucinatory experiences he had to be transferred to the psychiatric ward and was under my care. He recovered from his delirium in three days

Read before the ninety-eighth annual meeting of the Hawaii Medical Association, May 14, 1954.

[1] Bleuler, E. (Brill): Textbook of Psychiatry, McMillan Co., New York, 1924.

[2] Piker, P.: On Relationship of Sudden Withdrawal of Alcohol to Delirium Tremens, Am. Psychiat. 93:1387 (May) 1937.

[3] Bowman, K. M., Wortis, H., and Keiser, S.: Treatment of Delirium Tremens, J.A.M.A. 112:1217 (April 1) 1939.

after the use of I.V. fluids, vitamins and paraldehyde sedation.

Comment

This man must have had a certain degree of alcoholic encephalopathy at the time the fracture occurred. Certainly, the period in the hospital preceding the delirium was a period of abstinence from alcohol, but more important than that, it was an incubation period in which the effect of the bone fracture upon the alcoholic encephalopathy culminated in the delirium.

CASE 2.—A colored woman was involved in an accident in which she suffered multiple bruises, including a contusion of the scalp, three broken ribs and minor abrasions. Three and a half days after admission to the hospital she developed an acute delirium involving visual and auditory hallucinations and excitement associated with panic in response to her hallucinatory experiences.

At this time I was called into consultation and considered it as a case of concussion delirium. Spinal fluid examinations, X-ray of the skull and neurological examinations were negative. She was transferred to the psychiatric ward and recovered with supportive treatment in three days. Then it developed that she drank regularly, moderately to heavily and was intoxicated at the time of the accident.

Comment

Once again we have an individual who was a chronic heavy drinker who had a chronic alcoholic encephalopathy without any symptoms until she suffered three rib fractures. Once again we see an incubation period of three and a half days before the influence of the bone fracture upon the alcoholic encephalopathy culminated in the delirium.

CASE 3.—A woman, 40 years of age, drank very excessively and was more or less incapacitated by her alcoholism. She was in a constant state of inebriation with somewhat slurring speech, glassy stare, slow movement and slow cerebration. She certainly had alcoholic encephalopathy but there was no delirium. She suffered a compound fracture of the left tibia and fibula.

Three days after admission to the hospital she developed the typical delirium characteristic of alcoholism. There was a fluctuating contact with the environment. She passed from a state of relatively good contact with her environment to one of contact with an imaginary world with activities involving her home, people she knew and activities in which she engaged that were entirely hallucinatory. She was placed upon intravenous fluids, vitamins and paraldehyde sedation and recovered in three or four days.

Comment

Here again we have an individual who drank heavily, was almost constantly intoxicated clinically and who had alcoholic encephalopathy without delirium. Again there is a bone fracture, an incubation period of three to four days and then delirium tremens.

CASE 4.—A woman, 40 years of age, was operated upon for a dislocated lumbar disc. She was in the hospital one week before fixation of the spine was done. Four days after the operation she developed a typical delirium in which a vivid panorama of small people moved before her. There was a complete loss of time and space limitations. Boats moved through space with people in them and she watched these activities much as we look at movies.

Comment

This woman was the wife of a bartender, and after she recovered from her delirium we learned that she had been drinking steadily for a number of years. She had never been hospitalized for alcoholism and had never showed a disturbance of personality which interfered with her social or domestic adjustment. We are justified, however, in concluding that a chronic state of alcoholic encephalopathy did exist without gross clinical symptoms. During the seven days at the hospital preceding the operation she certainly was deprived of alcohol, but delirium did not ensue. The operative laminectomy and fixation of the spine, however, did exert a direct influence upon the alcoholic encephalopathy, and after an incubation period of three and a half days she developed a typical delirium tremens. Eighty mg of ACTH given daily intramuscularly aborted the delirium and she recovered in thirty-six hours.

CASE 5.—This is the most interesting case of all. A young man, 22 years of age, was sent in from another island in a state of debility resulting from chronic alcoholic intoxication. He showed gross incoordination in his movements and slurred speech, cerebrated slowly, and evidenced gross impairment of his thinking processes. Alcoholic encephalopathy was certainly present, but no delirium. He was very tremulous. He had not been drinking for days, so that the symptoms were not due to acute intoxication.

Following admission to the hospital he improved on intravenous fluids, vitamins and paraldehyde sedation. He then insisted on leaving the hospital, but was not permitted to do so, and that same day had two convulsive seizures with resulting severe pain in the thoracic spine. X-ray showed compression fractures of the 5th, 6th, and 7th dorsal vertebrae. The pain cleared up in a few days, but three days after the seizures he developed an acute delirium in which he actively engaged in imaginary activities which were part of his former experiences and evidenced only a slight contact with his immediate environment. He was placed on ACTH 80 mg daily and cleared up in thirty hours.

Comment

This case certainly represented an experimental set-up which involved deprivation, bone fracture, encephalopathy and delirium tremens. It gives us a clearer picture of the relationship. When he first presented himself he undoubtedly had encephalopathy, evidenced by the incoordination, tremors,

slurring of speech and poor cerebration. He was hospitalized four days. This period of deprivation did not result in delirium tremens, but he did develop alcoholic convulsive seizures. They demonstrated the presence of encephalopathy without delirium. In the course of the seizures he suffered traumatic compression fractures of the dorsal vertebrae. Again we have bone fracture exerting its influence upon the alcoholic encephalopathy, an incubation of three and a half days culminating in delirium tremens.

Conclusions

We have presented a rather unusual series of cases in which bone fracture in the presence of alcoholic encephalopathy, following an incubation period of three to four days, resulted in delirium tremens. Piker[2] has pointed out that 75 to 90 percent of all cases of delirium tremens occur while the person is drinking, and emphasized that the period of deprivation is not the cause of the delirium, but is the result of the alcoholic illness with its accompanying gastritis, hepatitis and general somatic dysfunction. In this series of cases bone fracture was the precipitating factor.

I offer no explanation as to how bone fracture can affect alcoholic encephalopathy so as to bring about delirium tremens, but certainly this group of cases does offer clinical evidence that the bone fracture is directly responsible, that it affects the alcoholic encephalopathy and that the so called period of deprivation is actually a period of incubation.

Discussion

DR. J. W. CONN: This is a very interesting observation which suggests a relationship between the alcoholic's response to stress and the precipitation of delirium tremens. It warrants careful study of pituitary-adrenal function, as well as hepatic steroidal function, in chronic alcoholics unexposed to physical injury. Despite the fact that administered ACTH is often successful in relieving the symptoms of delirium tremens, I would speculate from other experiences, that the chronic alcoholic cannot tolerate the known increase in brain excitability produced by the *sudden increase* of the level of circulating hydrocortisone which follows quickly upon exposure to trauma. Although this increased blood hydrocortisone level is apparent within hours after the traumatic experience, it may be forty-eight to seventy-two hours before the psychosis becomes clinically apparent. Such a psychosis could continue for two weeks after blood steroid levels had returned to normal.

Young Hotel Building

A NEW ASPECT OF TREATMENT IN THE PSYCHOSOMATIC DISORDERS

WILLIAM H. STEVENS, M.D., Honolulu

AS you may know, I recently returned from a year and a half on the mainland, and I want to say that it's a wonderful feeling to be back in the land of Aloha. One of the main purposes of this recent trip was to explore some of the latest advances in the ever-continuing search for shorter and more effective ways of treating the mental and emotional illnesses in general and the psychosomatic diseases in particular. Inquiring and conscientious therapists are constantly searching for the answers to such questions as: What IS psychotherapy? What are the effective ingredients of good psychotherapy? How can we best distill that which is effective from our previous methods and decant that which is not? What can be evolved in the way of an abbreviated but effective type of psychotherapy that will be of specific help in the dysfunctions of the central nervous system, which statistically make up more than one third of all the medical problems seen in doctors' waiting rooms?



DR. STEVENS

Happily for me, this search on my part seems to have coincided with a somewhat similar revolution going on on the mainland. I found many seemingly isolated, yet simultaneous uprisings among psychiatrists, clinical psychologists, and physicians in many different specialties who are really thinking psychosomatically, who are seriously concerned that emotional and psychosomatic illnesses now constitute America's No. 1 Health Problem, and who are keenly aware of the shortcomings of previous disciplines in the *treatment* of these disorders.

Reasons for the Change

This incipient revolution appears to be the resultant of several strong, concurrent forces, both cultural and scientific. First, a tremendous lay increase in, and awareness about, the personal and physical manifestations of anxiety and tension in this post-war Atomic age of ours. Modern novelists expose the subconscious dynamics of their main characters; movies and plays expand the theme, from the Snakepit to the Shrike; every housewife daily reads at least one magazine article entitled "Why Your Husband Has Hives", or "Your Feelings Can Make You Sick"; and I recently heard a bop tune quaintly titled "Psychosomatic Stomp."

Secondly, a manyfold increase in the demand for psychotherapy on the part of masses of people who ten years ago had never heard the word, and to whom psychotherapy has now become a symbol of help and service to the troubled individual in a number of different ways: People whose children may be getting expert counseling for school and personality problems; whose friends may have been relieved of hypertension or an ulcer through psychotherapy; whose relatives may have cured a nervous breakdown or prevented a suicide with psychotherapeutic help; or whose neighbor is a veteran receiving aid through the greatly expanded psychological facilities of the Veterans Administration.

A third force demanding a change in our methods, and I think very deservedly so, has been a general dissatisfaction on the part of patients and physicians alike with the results of previously existing types of therapy. Lengthy, cumbersome, costly, all too frequently ineffective . . . . "let's face it" . . . . I'm afraid that in many cases we haven't given some of our patients treated in the old, traditional ways a very good return on their investment.

Last, but by no means least, I would say that one of the healthiest and most important stimuli to the development of improved psychotherapeutic methods has been the fundamental and scientific impetus of the research men: observing, recording, testing—winnowing the chaff from the wheat—and applying, in the most difficult of the phenomenological fields to measure, the instruments of the scientific method and the criteria of statistical significance.

Guide Posts

I'm not going to belabor you tonight with slides and statistics, but I would like to mention

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a few isolated examples of the kind of work which has helped to guide us in the direction of shorter and more effective psychotherapy:

On the part of neurologists and neurophysiologists, the discovery that such intangible concepts as feelings, emotions and attitudes actually exist within the hypothalamic-autonomic system as measurable bio-electric reverberations, and that definite and lasting changes in their functional pattern can be achieved through successful psychotherapy.

Among the psychoanalysts a rapidly growing group, who for investigative purposes confine their explorations to a single psychosomatic entity or syndrome in a controlled series of patients, to track down the etiologic element or elements common to all; or who test the hypothesis that allowing patients to interpret their own dreams and associations definitely shortens the resolution of the transference neurosis.

Among general psychiatrists such work as that of the group at the Oak Ridge Atomic Community whose experience with hundreds of patients clearly indicated that the complete omission of the customary psychiatric history and diagnostic testing resulted in markedly shortened duration and distinctly better results in interview therapy.

Some of the most searching and helpful investigation has been done by the clinical psychologists, although it pains me somewhat to admit this, having always had a specific allergy to people who ask, "Doc, what's the difference between a psychiatrist and a psychologist?", and I have only been able to accept this state of affairs by remembering that, after all, the pathogenic bacteria were discovered by a wine chemist, digitalis by a charwoman, and vaccination by a milkmaid. Actually, who other than psychologists are better suited to concern themselves centrally with "PSYCHO"-pathology and "PSYCHO"-therapy? Fortunately, in meeting this broad challenge, more and more psychologists are entering clinical work and filling a much-needed place alongside investigators in the older professions.

If this be treason, just let me say that of all the places I visited on the mainland I think I was most impressed by the work on treatment that is being done at the University of Chicago Center for Counseling and Psychotherapy. There, well-controlled and objective studies in "Client-Centered Therapy" are being conducted by more than 50 psychologists, physicians, and social scientists in a coordinated research program.

Through the analysis of thousands of hours of electronically recorded interviews, of sound movies taken through one-way screens, through testing and re-testing research cases before, during, and after therapy, this pioneer group has spearheaded the post-war advance toward a new type of therapy which has already achieved widespread recognition as a definite "school of thought." Its findings have raised challenging questions concerning the therapeutic value of some of our old, traditional concepts in psychiatric treatment.

As a result of the interaction of these cultural and scientific forces I have just mentioned, there is evolving a new, basic concept of therapy in the psychosomatic and personality dysfunctions which I feel holds great promise for the future of psychological medicine, and which will be of considerable interest to you as a valuable addition to our therapeutic armamentarium in the treatment of your patients.

Self-directive Psychotherapy

I found it being called by several different names on the mainland: "Non-Interference Therapy"; "Interview Therapy"; "Nondirective Analysis"; "Client-Centered Therapy"; "Nondirective Psychotherapy"; "Abbreviated Depth Therapy", and "Minimal Activity Therapy." Not to confuse the issue further, (God knows we psychiatrists are polysyllabic enough already) but it seems to me that the term *"Self-directive"* best describes the central theme that is common to all of them.

Self-directive!—the idea that therapy progresses most deeply and most rapidly to a successful conclusion when the doctor allows the patient's own self-expression to direct him to his own nuclear, emotional conflicts. In the very simplest terms, this kind of psychotherapy is a warm, emotional communication between patient and therapist from which the patient emerges with permanently improved feelings and attitudes toward himself and toward the world around him; and, (of most importance to us medically) it is tension-relieving therapy!

Basic Characteristics of This New Self-directive Psychotherapy

First of all, the emphasis is on treatment, not diagnosis. Treatment starts the minute the patient sets foot in the door. We are finally learning that the complete and searching history so essential to good diagnosis and treatment in organic medicine is not essential in the treatment of many of the psychogenic disorders, and, in fact, may hinder the progress of psychotherapy very considerably! One reason for this 'revolting development' is that the patient who gets the 'third degree' in his first interview with the therapist feels

completely justified in sitting back in his chair with the attitude: "OK, Doc, you've got all the answers, now you make me well." This is precisely the attitude you want in every other branch of medicine that I can think of, but in psychiatry we are discovering that this authoritative, "master and slave" type of relationship discourages the development of the patient's emotional initiative and self-dependence, which are so vital to rapid therapeutic progress. (As a matter of actual fact, if for any reason you should want a history of the pertinent psychopathological features in a given case, a reconstruction of the patient's spontaneous verbalizations in retrospect will give you a much more dynamic and truthful picture than could ever be obtained in a question and answer way before therapy.)

A second reason for not wasting the patient's time and money in preliminary history-taking and diagnostic testing, although here again we are reversing a basic precept in physical medicine, is that in most psychoneurotic and psychosomatic problems, the diagnosis does not alter the treatment in any way! Just as the discovery of penicillin abolished the need for the specific typing of the various strains of the pneumococcus, it is now sufficient for us to know that the patient is suffering in some way from autonomic or emotional stress, and that he needs basic tension-relieving psychotherapy. Even in the occasional patient who may require insulin or electrocoma shock therapy to regain a working contact with his environment, we are coming at last to the view that these adjunctive treatment methods are but preludes to reintegrative psychotherapy.

A second basic characteristic of self-directive psychotherapy is that the healing power comes from within the patient and is not—and, for that matter, cannot—be injected or transfused by the doctor. The modern therapist is merely an assistant, a catalytic agent whose therapeutic presence helps to facilitate a reaction within the patient resulting in autonomic recompensation, or emotional re-integration. This inevitably leads to expanded insight and better self-understanding, as an epiphenomenon, without active interference on the part of the therapist.

At first glance this would seem to violate the time-honored attitude of the physician: "Bring me your sickness and I will make you well." A second glance, however, will remind us of something we frequently overlook: that although the doctor provides the antibiotic to accelerate the process, the patient's own humoral and cellular defenses ultimately heal the infection; and that although the doctor may facilitate approximation and immobilization in a fracture, the permanent healing must come from within the bone.

In these same terms, then, I like to think of today's self-directive therapist as somewhat like a surgeon, whose skilled incision releases the toxic accumulation from within a tense, painful abscess and makes it possible for the wound to heal from within. We have been surprised and encouraged to find that within even the most damaged personalities are strong positive forces which tend toward growth and health if we can be skilful enough to release them from the repressing effect of negative attitudes and feelings.

This brings us to a third basic characteristic of this type of therapy: It deals almost entirely with how we FEEL, and has little to do with what we KNOW. Every good therapist has a highly developed "third ear" with which he automatically screens out the content of his patients' verbalizations, and listens intently for the feeling behind the words. As he skilfully and warmly responds to these hidden undertones and reflects them back to the patient, he helps him bring to awareness for the first time the real meaning of his illness, or of his behavior, and facilitates the development of truer insight.

Our accumulated clinical and research experience tells us that this real emotional insight, which is so important in healthy personality functioning, cannot be imparted to the patient by the therapist, even with all his superior knowledge. Intellectual insight—yes!, but when it comes to the autonomic nervous system, "feelings don't listen" to directions from outside, or, as every layman knows: "A man convinced against his will is of the same opinion still!" The kind of insight that is really effective comes from within the patient, and is usually phrased in terms best suited to him, rather than in the 'gobbledygook' of the psychiatrist. I certainly know from my own experience that it is therapeutically much more valuable for the patient to be able to bang his fist on my desk and say with real feeling: "I've been a 14-karat JERK—a weak-kneed, asinine nincompoop!", than it is for me to tell him that he is a passive-dependent, psychosexually fixated individual with an unresolved Oedipus complex!

In this same vein, we have learned from repeated and painful experience that advice, reassurance and persuasion serve no useful function in effective psychotherapy. While they may have some place in general medicine or in the minister's chambers, we know that they are not productive of the lasting changes in attitude and behavior which are our goal in therapy. These time-worn but commonly used maneuvers are actively avoided in

modern psychotherapy, because they delay progress. They tend to *deny* the actual feelings that exist within the patient, and lead to further repression rather than healthy ex-pression. You and I have yet to meet the patient whose involuntary, vegetative nervous system can obey the command: "Stop worrying!" Anxiety and tension are deaf to reassuring words, and the dependent patient who pleads for answers to his problems will never grow to stand on his own emotional feet if we attempt to solve them for him.

Paradoxical as it may seem, psychotherapy is not a problem-solving procedure in itself. The emphasis is on the person behind the problem. We are now confident enough in our experience to predict that if we can help the patient to become aware of his inner feelings and attitudes, he will begin to face situations in a more mature, realistic way and will learn to solve his own problems without our help.

Self-directive psychotherapy departs from tradition in another startling way: It deals more with present feelings than with past experience.

We have traditionally been accustomed to take a "genetic" or longitudinal approach to psychopathology, and to force our patients to go back to childhood and relieve, or "abreact," past traumatic experiences. This hallowed custom has been the cornerstone of practice in both the older psychobiological and psychoanalytical persuasions, and to its use by such brilliant pioneers as Adolph Meyer, Sigmund Freud, and their many disciples both living and dead, we owe a tremendous debt of gratitude for most of our present knowledge of dynamic psychopathology. We can give only the highest praise to these men, and to their schools of thought which have made such fundamental contributions to the science of human behavior. And we do not detract from their glory in the least when we are now forced to admit, as with so many original, investigative procedures, that a clinical technique which greatly enlightens our knowledge of a disease is not necessarily the most effective method in the treatment of the disease. Psychoanalysis is, unfortunately, a lengthy and expensive procedure. If equivalent results are possible with a briefer procedure, one more applicable to the general practice of medicine, then there is considerable urgency to develop these shorter techniques.

A very encouraging finding in self-directive therapy is that clinical changes just as deep and lasting can result from current experience; from the moving and pervasive experience of the therapeutic relationship itself, which just as effectively resolves the pathological residual of past experience, and in a much shorter time. In actual practice, some patients will elect of their own accord to follow the historical route in their self-exploration, but it is surprising how many people "get well" without ever departing from the present tense in their verbalizations!

Finally, self-directive psychotherapy has a characteristic that is refreshingly different, from some of our older techniques, at any rate; IT WORKS! And it sometimes works in a rapid and dramatic way that would surprise those who have not seen it or experienced it. If the therapist is mature enough to resist his natural tendency to ask and answer direct questions, to make the obvious interpretations, to give advice and reassurance, or to allow the patient to slide comfortably into a dependent transference relationship which may take months or years to resolve, then the patient's own anxiety and inherent power for growth will usually carry him past the 'point of no return.' Very shortly he will find himself progressing under his own power with no further need for the therapist's support and assistance. He has been able to abandon his psychosomatic refuges, to drop his psychoneurotic defences, and now he is ready to lay aside his psychotherapeutic "crutches." This is our goal in therapy.

Well, by now you are probably convinced of something you suspected all along: that "All psychiatrists are crazy, and that a person who would go to one ought to have his head examined!" I don't blame you! I well remember my own violent reaction when I was introduced to this concept a few years ago: "What!—no history, no testing, no interpretations, no advice, no reactivation of the transference neurosis? Preposterous! Ridiculous!" I can only tell you that as I was gradually able to work through my own initial resistances, to unlearn some of the therapeutic attitudes introjected in my earlier training, to reopen my mind to the whole subject of psychotherapy in a more objective way, I have eventually come to accept this concept as one having real value in the practice of medicine and psychiatry. From my own personal experience and from the rapidly growing body of research and clinical evidence, I am by now convinced that we have a new and highly effective treatment method to add to our armamentarium in the mental, emotional, and psychosomatic diseases.

Selection of Patients

Just a word about what patients are candidates for this type of therapy: Theoretically, its basic principles apply to a wide range of human disorders, and there is already interesting evidence of its effectiveness with children, with actively psychotic patients, with reasonably "normal" per-

sons who wish to expand their capacities for mature living, with small therapy groups who cannot afford individual treatment, and even with the mass neuroses that develop in labor and industrial strife. For our practical consideration here, let's just say that in the medical field any patient with a "decompensated personality"—whose total anxieties and tensions have exceeded his psychophysiological threshold and are spilling over into behavior disorders or distressing physical symptoms —is a candidate for self-directive psychotherapy.

This obviously includes the anxiety states, the phobias, the conversions, the insomnias, the anorexias and the headaches that do not respond to the usual symptomatic and supportive treatment. It certainly includes most variations of the ambulatory, psychoneurotic patients who complicate your practice and who account for most of your unnecessary night calls. It includes the incipient psychotic patient—the borderline schizophrenic who is losing the struggle to stay in contact with reality; the depressive who is losing the inner battle with his will to live. And it most certainly should include the patient with the psychosomatic or psychophysiological disorder because help is long, long overdue in this neglected group of patients.

Until rather recently our knowledge of the basic causation of this group of diseases has been tentative and incomplete. When you and I were in medical school they were labeled "idiopathic, cryptogenic, possibly functional," or mostly, "cause unknown." We are now quite certain of the psychic etiology of many of these diseases, and increasingly certain of a growing list of others for which no primary organic cause has ever been found. If we are to treat the whole person and not just his secondary symptoms, we must broaden our therapeutic vision to include a working awareness of his inner personality. If we are to do more than just treat organic end-results, we must bring him specific help for the nuclear emotional conflicts which result in autonomic stress and vegetative dysfunction, for these are the common denominator of all the psychosomatic diseases.

Amenable Diseases

I wish I could explore with you the fascinating story of just how these unresolved emotional conflicts "bore from within" and produce such real, and even irreversible, changes in the function and structure of the somatic part of the body. But since THERAPY is our theme, let me just list some of the disorders that we now know to be entirely or chiefly due to autonomic stress:

(1) In the Gastro-Intestinal System,
- Anorexia nervosa
- Bulimia (excessive hunger—obesity)
- Pernicious vomiting
- Cardiospasm
- Globus hystericus
- Gastric hyperacidity and chronic dyspepsia
- PEPTIC ULCER
- Chronic diarrhea
- Spastic and Mucous colitis
- ULCERATIVE COLITIS
- Psychogenic constipation

(2) Among the Cardiovascular Disturbances,
- Neurocirculatory asthenia
- Chronic anxiety, tachycardia and arrhythmias
- ESSENTIAL HYPERTENSION
- MIGRAINE HEADACHES
- Coronary thrombosis ?
- Acrodynia

(3) In the Respiratory System,
- Vasomotor rhinitis
- Hysterical aphonia
- Constrictive dyspnea
- BRONCHIAL ASTHMA

(4) Among the Skin Diseases,
- Neurodermatitis
- Eczema
- Angioneurotic edema
- Urticaria
- Functional pruritus
- And many others

(5) Among the Endocrine Diseases,
The controlling effect of the vegetative nervous system on the ductless glands is most clearly seen in THYROTOXICOSIS, DIABETES MELLITUS, and the fatigue states due to HYPERINSULINISM.

(6) Chief among the disturbances of the Musculo-Skeletal system are,
The many varieties of conversion paralysis, accident proneness, and RHEUMATOID ARTHRITIS.

(7) Among the Dysfunctions of the Sexual Apparatus,
Psychological factors head the list by a wide margin, all the way from frigidity and impotence to the bizarre sexual deviations, which you will find presented in a much more interesting fashion in the little known works of an obscure zoologist named Alfred Charles Kinsey.

There are many others that swell the list to account for a total patient population with more than a half of all the diseases that plague the world today. If you are still having trouble visualizing or accepting some of these apparently organic disorders as chiefly psychological in origin, just remember that the basic etiology is SUBconscious—beyond our power to observe directly—and that the sympathetic and parasympathetic regulators of somatic function operate involuntarily and relentlessly twenty-four hours a day whether motivating normal peristalsis or abnormal vasomotor constriction.

Prognosis

Just a word about prognosis and limitations. As with any disease in medicine, the younger the

patient, the earlier the treatment, the less virulent the disorder—the better the prognosis. If you wait until chronic autonomic stress produces irreversible secondary changes in the end-organs of the body, the prognosis for psychotherapeutic cure will obviously be limited.

Patients have limitations, too; in time, in money, in understanding, and in their ability to accept the psychotherapeutic point of view. They probably wouldn't believe you if you told them they'd rather be sick than unhappy, but it's true—half the disorders you see are due to repressed emotional unhappiness! Perhaps that's where the word DIS-ease comes from!

Limitations

The critical limitation of psychotherapy, though, is in the therapist himself. Not necessarily in his formal training, or his intellectual knowledge, or even in the therapeutic school of thought he represents, but in WHAT KIND OF A HUMAN BEING HE IS. His personality is the only real therapeutic tool he possesses, and unless he is comfortable in himself, he cannot help his patients' discomfort; if he lacks warmth and human understanding, he cannot "thaw out" frozen assets and promote self-understanding in his patient. Unless he himself is relatively "normal," he cannot hope to stimulate growth in the ABnormal.

There is an interesting piece of research which indicates that topnotch therapists, regardless of how far apart their schools of thought may be, tend to create very similar relationships with their patients. They seem invariably to have these attributes in common:

(1) Warmth, understanding, and unlimited tolerance.
(2) The ability to get down on the patient's level and share his emotional experience with him.
(3) A depth of interpersonal communication—"emotional diathermy" if you will—which, for lack of a better term, we will call EMPATHY.

Presumably all good therapists are getting closer and closer to some basic process which IS psychotherapy.

Conclusion

And now for a purely personal epilogue: I for one am greatly encouraged by this new and different therapeutic philosophy. As we make explicit that which has been implicit, as we extract the science from the art, we become equipped for perhaps the first time in history to translate psychosomatic medicine from an academic concept into a practical, working branch of medical science. And there is a distinct "differentness" about this new concept which has great appeal for me, though it may seem unorthodox or precocious to others. I find myself wondering if it will turn out to be the same kind of "differentness" that initially characterized the scientific hypotheses of Newton, Darwin and Freud. I cannot say as yet whether this prophesy is realistic or merely wishful thinking, . . . but I am going to do all I can to find out!

280 Lewers Road

PAIN . . . THE IMPORTANCE OF ITS PROPER EVALUATION

J. WARREN WHITE, M.D., Honolulu

THE approach to a discussion of pain is almost invariably devoted to the problem of its relief rather than to voicing an appreciation of its importance in maintaining our well being on this planet. While it is recognized as one of the cardinal symptoms of inflammation, it is thought of, too often, more as a malignant rather than as a helpful factor in caring for syndromes characteristic of disease entities.

Etymology

In addition to my concern as regards the interpretation of the causes of pain as a physician, my interest was possibly first aroused years ago in hearing a sermon discussing pain as the penalty for wrong doing. In the old Calvinistic doctrine, pain was considered to be the penalty for previous sins committed by either ourselves or our forbears. A rebellion against this idea took place long before I started studying medicine.

The misuse in handling such a subject in a sermon was a natural one, as the word "pain" comes directly from the Greek root meaning penalty or punishment. In a late unabridged Webster's Dictionary, the meaning of pain as being punishment is put down as obsolete, except in such expressions still in common use as "on pain of death." It cites as an example, "A sentry during war time must not sleep when on duty 'on pain of death'." Our old-time religion was based much more on fear than the doctrine presently handed down to us from the pulpit, although even now, I feel that preachers too often use the threat of reprisal to influence our behavior. There, again, the "art" of a clergyman is somewhat in the same category as the "art" of the practice of medicine. Art, I like to think, is fundamentally an understanding of all angles to a problem and with this knowledge to practice our profession in a skillful way for the ultimate benefit of the patient.

Pain, as such, is not mentioned specifically in the Hippocratic aphorisms. Such symptoms as fevers, gout, humours, evacuations, swellings, are extensively discussed, but only one mentions most casually both pain and the absence of pain. In the recent edition of Dorland's medical dictionary, twenty-eight different kinds of pain are enumerated.

Pain is the commonest symptom which brings the patient to either the doctor or the drugstore. The dispenser, be he a physician, druggist or "quack," is justifiably criticized for simply giving a "pain killer" and slighting the search for the cause.



DR. WHITE

In taking the history of a patient, great care must be exercised in making an accurate analysis of the chronological development of painful symptoms. Too often are we, even as physicians, satisfied by simply taking or being given something for physical relief, and it is the exceptional drugstore employee who will not, at least at first, hand out something to a purchaser and tell him to "try this." The medical advertisements in lay magazines, along with short cuts in slenderizing programs, have largely to do with the medical relief of pain or its corollary, fatigue.

Importance of Proper Interpretation

Too frequently do we tend to be ungrateful for the fact that the type of warning pain I am discussing is a God-given admonition which must be heeded. If after thorough search an organic cause does not appear, we are too prone to wonder if our patient is malingering or at least exaggerating. When we become distracted by our lack of success in finding the cause of pain, we again too often think, to use a most trite expression, even if we do not admit it to ourselves, that a patient is "nuts." A young medical graduate has not practiced long before he finds that subsequent developments in a complaining patient sometimes show that after all that patient had adequate cause for his lamentations.

The interpretation of symptoms, particularly pain, is the real test of the physician's acumen and constitutes in a large measure the "art" respected as much even by the ancients. It is well

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always to have in mind Hippocrates' first introductory aphorism: "Life is short, the art long, opportunity fleeting, experience treacherous and judgment difficult." If we firmly believe that there is no organic cause for the pain, we must do more than tell the patient that he is well and healthy to look deeper in our attempt to give relief even in a fancied ailment.

Our various cults and faith healers exist on just such instances. Every physician is really his own psychiatrist, and it is only in the major problems or for necessary confirmation of the physician's own conviction that the specialty of psychiatry was one of the first to become organized. Pain without an organic cause unquestionably occurs frequently and demands great skill and art for its proper evaluation and control. We must be forever on our guard, however, in such interpretations.

Longevity of Female Explained

Although Kipling has justifiably written that the female of the species is more deadly than the male, he has not discussed the greater tendency of the so-called weaker sex to experience pain. We all agree, however, that although her threshold level is lower, she is able to tolerate pain better than the male. This fact explains to a large degree, in my estimation at least, her extended life expectancy. These four or five years longer that a woman lives, in spite of the hazards of childbirth, is explainable on the basis of her lowered pain threshold. This fact, I believe, is one of the important details in our Creator's overall plan of existence.

Need for Adequate Investigation

It is forever the temptation of even the successful (and therefore over-worked) physician to skimp in his investigation of the cause of pain, and he is too prone to furnish the relief for which the patient has presented himself. Nature does her best to inform us when something is wrong, and sees to it, usually, that we are alerted in no uncertain way. It is when this natural mechanism goes wrong that serious trouble is more liable to develop. In treating head and abdominal pain, we are, in our teaching, repeatedly and constantly warned against giving medication which would tend to mask important symptoms primarily associated with pain. Pain is the chief symptom causing us to perform what later prove to be unnecessary operations. We do not have to be adept salesmen to persuade a patient to be operated upon if he is in pain.

Trauma and Pain

Much of my approach to this problem is necessarily influenced by my special interest in orthopedic surgery. Some of the most severe pain experienced is associated with major injuries such as fractures, but even here, there is a vast difference difficult to explain. The excruciating pain I experienced some years ago when the tip of my middle finger was amputated was far in excess of the mediastinal pain during my recent heart ailment.

It is in those cases where for some reason or other, there is an absence of adequate pain that we fall into difficulties. It is the situation where pain is expected and does not occur which is of particular interest, and is one of the stimuli which urged me to record some of these ideas. My main thesis, however (allow me to reiterate), is the important part ordinarily played by pain and sensitiveness in our daily life.

The relief of metatarsalgia by the removal of a pinched nerve does not fall into this category. If the nerve continues to be pinched between the metatarsal heads, it is of little importance. The associated anesthesia of the toe never causes any disability and no treatment would be needed were it not for the pain. Sciatic pain is far different, being frequently out of proportion to the physical disability caused by actual anesthesia or paralysis.

A Personal Experience with Pain

I experienced for about three quarters of an hour, some months ago, severe but not excruciating pain in the region of my posterior lower mediastinum. This was not preceded or followed by angina or what could be called anginoid pain, and the diagnosis of coronary occlusion had to be made largely on the electrocardiogram, rather than the other usual symptoms. I had no fear of impending death or the excruciating pain I ordinarily associated with a "coronary," and had I not had the warning pain, moderate as it was, I might not be here reading these brief remarks. Even now, because of the lack of pain or fatigue, I have found it most difficult to cooperate with my physicians, and tend to react adversely to the continual advice to "slow down." I truly am trying to restrict my activity, however, one might say, "on pain of death;" but because of the lack of pain or even early fatigue, it is difficult.

In addition to the rebellion against the discussion of pain as a moralistic penalty for past wrong doing, I have, since going into orthopedics particularly, been interested in it or the

lack of it as a symptom of disease, using it in the true meaning of that word: dis-ease.

Only last October at the meeting of the Western Orthopedic Association at Sun Valley, one of our members wrote a most important paper on the congenital absence of the ability to experience pain in certain individuals, particularly children. That congenital abnormality had never been recognized by me and it may have been that this contribution was the stimulus which urged me to present this title.

Anesthesia Hampers Treatment

Since going into orthopedics where so frequently "by main strength and awkwardness" we accomplish our objective, I have been impressed with the value of pain in warning us when we have gone too far. Possibly, again, it is the negative side of the subject which has been so important. That is how handicapped we are when our patients do not have pain to warn us that we are in difficulty.

One of the reasons I have been particularly interested in Hansen's disease has been the fact that by and large, these individuals suffering from that condition live without pain. As a result, many complications develop which the pain-perceptive individual escapes. The predilection of Mycobacterium leprae for peripheral nerve tissue produces a sensory disturbance sufficient to require constant vigilance to prevent decubitus, eye complications, joint degeneration and a multitude of other difficulties developing further from this deficiency. Many times have we seen patients suffering or I might better say inconvenienced from this distressing condition long after an unrecognized fracture or dislocation has been sustained, i.e. the inability to experience pain when others than the patient himself have noted a deformity developing. One patient over at Kalaupapa even developed an elbow decubitus after becoming too long engrossed in playing Canasta.

All patients developing pathological conditions producing sensory deficiencies—usually, of course, of central nervous system origin—must receive constant extra care. The paraplegic with his decubitus and his genito-urinary complications is eternally with us.

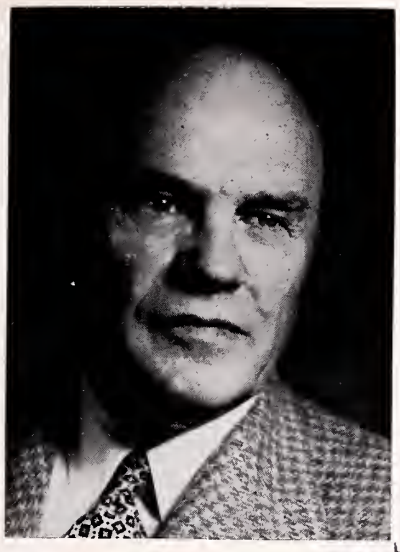
Conclusion

As a final word, let me reiterate that we must be forever mindful, in our true understanding of both its physiology and pathology, of the true value of pain, regardless of whether it be fancied or consistent with the circumstances. If fancied we must look deeper psychologically or psychiatrically; if consistent, it gives us invaluable information in treating the physical condition causing it.

From the time we are a squalling newborn in our entry into this painful world until we are through with our damaged and worn out carcasses, we are dependent for our well being on pain or its close ally, fatigue. From the time we take our hot bath in the morning to the unconscious shifting of our position after falling asleep at night, we are protected by our sensorium. Hundreds of opportunities occurring during the day might jeopardize our well being were we not so well protected. In standing we unconsciously shift our weight from one foot to the other, in sitting we shift from one buttock to the other to avoid decubitus, the pressure sores which are the plague of entities associated with the lack of ability to feel.

It behooves us in our heroic efforts to combat pain to respect it and be grateful that our Creator has endowed us with the possession of such protective mechanism.

1020 Kapiolani Street (Straub Clinic)



NILS P. LARSEN, M.D.

The President's Page

During the past two months the Professional Services Committee have held many meetings and much progress has been made.

After meeting with the hospital directors and administrators, a joint hospital committee was formed. This committee we hope will find leaks and inefficiencies so that real savings can be made in the cost of hospitalization.

One of the wastes found in hospitals is trying to carry the many different kinds of pills and capsules that are kept on the shelves to cater to doctor tastes, i.e. there may be six different kinds of penicillin and dozens of different kinds of mixed vitamins or estrogens. If each drug room carried just one type of each and doctors learned to use that type in that hospital, costs would fall. We all must cooperate and help in this movement to lower the cost of hospitalization.

Mr. Harold Dillingham, who has repeatedly urged us to think in terms of total community good whenever we are thinking of medical care, wrote us, ". . . the trustees of the Kauikeolani Children's Hospital . . . July 26, 1954 . . . unanimously voted to drop further consideration of Mr. Kaiser's request for beds at the hospital." However, this conclusion is based on the assumption that we will assume responsibility to cooperate and develop a plan that will give better service at a cost that each person can afford. This is our chance to work for the total community good. Since Children's Hospital has cooperated so completely, I think it is up to us to see that they do not run at 50% capacity. They are trying very hard to give the best service.

Another outstanding businessman of this community wrote, ". . . a statement by the retiring head of the AMA to the effect that the time had arrived when the doctors of America must realize that their charges could not be based on the depth of a man's pocketbook." Perhaps it is time that we got together and developed a medium fee schedule so that insurance companies, as well as patients, can know just what the going charge is for various types of care. He also added this comment, "There is no such thing, under today's taxation and inheritance costs, as a group 'with unlimited means.' Those who were wealthy, through inheritance or as a result of their own labors, today face a taxation schedule which makes it impossible under ordinary circumstances for them to have any amount of venture or risk capital."

Times are changing—we musn't drag our feet.

Nils P. Larsen

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[EDITORIALS]

Rendezvous in the Hypothalamus

A good many years ago a lot of people concluded, on the basis of little or no evidence and lots of intuition, that emotional reactions could cause disease. They weren't very particular, for the most part, about what diseases or what kinds of diseases could be caused in this way, and their view of the whole problem seemed, to observers of more skeptical and scientific bent, to be oversimplified beyond all reason. A lot of them went on happily believing it, however, though the more sensible among them were willing to admit that vaccination, and plaster casts, and antibiotics, had their place in the scheme of things.

At about this same time, neurological research was gradually localizing more and more of the emotional functions of the brain down among the basal ganglia, in the hypothalamus—all without much reference to the possible interrelationships of this area with even normal body function, let alone the malfunctioning of disease.

Come now the mid-twentieth-century endocrinologists, as exemplified by Professor Conn in this issue of the JOURNAL, to tell us that the protective pituitary-adrenocortical mechanism is probably activated, either primarily or secondarily, by something that goes on in the hypothalamus, so conveniently situated right above the pituitary. The hypothalamic-pituitary axis seems to be both humoral and neural; but how it works, and just what activates it, are yet to be discovered.

Be that as it may, the toilsome climbing of medical research workers has finally brought them to a portion of the body where they will find —allegorically speaking—the Christian Scientists and other faith healers sitting and waiting for them. They're keeping a rendezvous in the hypothalamus.

Nine Doctors and God

The Honolulu County Medical Library's Endowment Fund and the triennial assemblies of the Pan-Pacific Surgical Association already stand as permanent memorials to Dr. F. J. ("Pete") Halford.

A third memorial—the work of his own active and enterprising mind and spirit—is being unveiled in time for the Sixth Congress of the Association. It is his medical missionary history of Hawaii, *Nine Doctors and God,* a beautiful 336-page volume published by the University of Hawaii Press.

A review of the new book appears on page 50 of this issue of the Journal. We recommend it to your attention because we think you'd enjoy reading the book. We did.

Ask Your Wives to Join the Auxiliary!

The Woman's Auxiliary to the Hawaii Medical Association and its three county divisions are rounding out six years of growth and useful service. They fill real needs, and their members are having a lot of fun doing it.

Some doctors' wives haven't joined—a good many, in fact. They've held off for a variety of reasons, none of which seems very sound. Some have said they are too busy at home, with small children, or that they are working; but active participation is not a requirement of membership, and the moral and financial support of wives who cannot play an active part would be most welcome to the organization. If they don't know the other doctors' wives, this is the best way to get acquainted.

To those who are willing to play an active part, in committee work, or special projects, or as

officers, we can offer the assurance that they'll be welcomed. No self-perpetuating clique runs any of the Auxiliaries; they are all democratic organizations (with a small "d," that is).

Doctor, if your wife operates on so close a budget that she's reluctant to fit Auxiliary dues into it, please make her an annual present of a check for $4, made out to the Woman's Auxiliary to your county medical society, and urge her to join it if she hasn't already done so. The more, the merrier—and they're helping the doctors a lot!

Congratulations, St. Francis Hospital!

A forward step in interne and resident training in Hawaii was taken last month by St. Francis Hospital when its active staff voted to permit the routine use of private pediatric patients for teaching ward rounds. Only if the physician requests that they not be visited for this purpose, will they be passed over on rounds.

This practice, which has been in satisfactory operation at Kauikeolani Children's Hospital for several years, is made necessary by the gradual decrease of non-paying, City and County or Department of Public Welfare cases in the wards. It has the approval of the Committee on Hospital Accreditation, as it must have the approval of all thoughtful persons. It can only work toward the improvement of standards of medical care for the patients concerned and of the pediatric teaching program in the hospital.

St. Francis Hospital is to be congratulated for being the first general hospital in Honolulu to establish this important aid to its interne and resident training program.

"Lyophilized" Doesn't Mean "Freeze Dried"

The word "lyophilized" has no official sanction as yet, but it will probably get into the dictionaries eventually. When it does, it won't be a synonym for "freeze dried" or "fresh frozen," even though it is currently being used in this way—for example, to describe blood vessel grafts preserved by freezing.

It will presumably mean "made readily soluble," by derivation from "lyophile," which means, literally, "loving to be dissolved," from the Greek *lyein,* to dissolve, and *philein,* to love. "Lyophile" was first popularized medically by application to plasma dried by freezing and vacuum, so that it would go readily into solution again on addition of water—which plasma dried by heat would not do.

Lyophilized vascular grafts, even if they could be made, would be worse than useless, for they'd dissolve as soon as they were wet by blood. Preservation by freezing and drying, in this case, doesn't make the treated material lyophile.

One-syllable words are all right, even for doctors; and this is one of many instances in which two of them are more exact by a good deal than one with four syllables. Vascular grafts are freeze dried. Let's just say so.

Sixth Congress Pan-Pacific Surgical Association Honolulu, October 7 to 18, 1954

Hundreds of delegates are expected to arrive October 7 on the Lurline, heralding the opening of the Sixth Congress of the Pan-Pacific Surgical Association. Further arrivals by air will swell the ranks of the largest surgical meeting ever to be held in Honolulu, with representation from fourteen countries.

The basic aims of the Association, as set forth in 1929, are to bring together surgeons from countries bordering on the Pacific Ocean to permit the exchange of surgical ideas and methods; to develop an acquaintanceship among the surgeons so that they may be instrumental in developing a spirit of good fellowship among the races bordering on the Pacific Ocean; and to further the principles of hospital administration and standardization.

The scientific program has been divided into two main categories: specialty sections and the Hospital Institute. The Hospital Institute will be conducted by four of the most outstanding authorities in hospital administration: Doctor Edwin Crosby, Director of the American Hospital Association, Doctor Robin Buerki, Director of the Henry Ford Hospital, Doctor Edward Leveroos, Director of the Division of Hospitals of the American Medical Association, and Doctor F. R. Bradley, President of the American Hospital Association. These meetings will be held separately from the specialty sections.

Some of the eminent speakers to be heard at the Opening Session and the Public Forum are The Surgeon General of the United States Army, General George E. Armstrong, The Surgeon General of the United States Air Corps, General Dan C. Ogle, and The Assistant Secretary of Defense (health and medical), Doctor Frank B. Berry.

The specialty sections will be held Monday, October 11, through Friday, October 15, starting each morning with breakfast clinics and con-

tinuing until noon with formal sessions. The program committee, with Doctor Joseph E. Strode as chairman, has worked for over two years to develop the extensive program. Assisting Doctor Strode in the specialty sections have been: General Surgery, Doctors Robert Johnston and Gilbert Freeman; Obstetrics and Gynecology, Doctors Satoru Nishijima, Lyle G. Phillips, Richard Sakimoto, and Robert Hunter; Orthopedics, Doctors J. Warren White and Steele Stewart; Otolaryngology, Doctors Tadao Hata, L. Q. Pang, and John Frazer; Ophthalmology, Doctors Raymond Ogawa, O. D. Pinkerton, and Robert Wong; Urology, Doctors R. O. Brown and Andrew Morgan; Neurosurgery, Doctors John Lowrey, Thomas Bennett, and Ralph Cloward. As we go to press, the program is as follows:

PRELIMINARY SCIENTIFIC PROGRAM

General Surgery Section

ARTHUR ALLEN—Cancer of the Colon

LYON APPLEBY (Canada)—The Precarious Blood Supply of the Common Bile Duct

YOICHI AZUMA (Japan)—Blood Transfusion and Blood Bank in Japan

HARRY E. BACON—Rectal Cancer: Inferior Mesenteric Regional Lymph Node Dissection with Ligation of the Inferior Mesenteric Artery at its Aortic Origin. Report of 243 Cases

H. GLENN BELL—Troubles in Gall Bladder Surgery

R. RUSSELL BEST—Technical Considerations in Sphincter Preserving Operations for the Rectosigmoid Area

ABEL CANONICO (Argentina)—Cancer of the Anal Canal

HOWARD D. COGSWELL—The Surgical Lesions of Coccidioidomycosis

WARREN H. COLE—Strictures of the Common Duct

WILLIAM H. DANIEL—Villous Adenoma of the Rectum

PAUL DUMKE—Use and Abuse of Blood and Expanders in Major Surgery

ROBERT ELMAN—Common Problems in the Nutritional Care of Patients

LAURENCE FALLIS—Total Colectomy for Ulcerative Colitis

HAROLD L. FOSS—Surgical Treatment of Chronic Segmented Ileitis

LEON GOLDMAN—Unusual Manifestations of Hyperparathyroidism

IAN HAMILTON (Australia)—Some Thoughts on Gastrectomy for Peptic Ulcer

STUART HARRINGTON—Three-Year to Forty-Year Survival Rates Following Radical Mastectomy for Carcinoma of the Breast

FRANK HARTMAN—Critical Evaluation of Available Plasma Expanders

J. WILLIAM HINTON—Experimental and Clinical Data Determining the Operation of Choice in Duodenal Ulcer

C. KENNETH HOLLOWAY—The Military Surgical Aspects of the Chosin Reservoir Withdrawal

CLAUDE HUNT—Surgery for Cancer of the Stomach—Subtotal Versus Total Gastrectomy

ROBERT H. IVY—Present Trends in the Management of Cleft Lip and Cleft Palate

W. RANDOLPH LOVELACE, II—Congenital Lesions of the Neck: Diagnosis and Surgical Treatment

RAYMOND McNEALY—The Surgical Management of Parotid Gland Tumors

HERBERT WILLY MEYER—Malignant Melanoma

DAVID MILLER—Procto-Sigmoidoscopic Findings

KOMEI NAKAYAMA (Japan)—Resection of the Cardiac Portion of the Stomach with Resection of Spleen and Tail of the Pancreas

GEORGE PACK—Definition of Adequate Surgery in the Treatment of Cancer

W. JOHN PANGMAN—Use of Ivalon (Polyvinyl) Sponge in Surgery

WILLIAM F. QUINN—The Use of a Plastic Nasal Tube for Simultaneous Suction and Feeding in 300 Gastric Resections With and Without Vagotomy

I. S. RAVDIN—The Adenomatous Polyps of the Large Bowel

PAUL REKERS—Tissue Transplantation

JONATHAN RHOADS—The Surgical Management of Pancreatic Tumors

FRANCIS F. RUNDLE (Australia)—Some Clinical Research Observations in the Course of Biliary Surgery

ROBERT A. SCARBOROUGH—Surgical Treatment of Chronic Ulcerative Colitis

HENRY H. SEARLS—Carcinoma of the Thyroid

VINTON E. SILER—Important Clinical Factors of Acute Pancreatitis

KENNETH STARR (Australia)—The Modern Approach to Pancreatitis

RUPERT TURNBULL, JR.—Mucosal-Grafted Ileostomy: a Technical Advance in the Surgical Treatment of Ulcerative Colitis

HENRY H. TURNER—The Use of Radioactive Iodine (I^{131}) in the Diagnosis and Treatment of Thyroid Disorders

MARIO GONZALEZ ULLOA (Mexico)—The Treatment for Burns and Cutaneous Abrasions

JEROME URBAN—Extension of Radical Mastectomy to Include the Internal Mammary Lymph Node Chain

OWEN WANGENSTEEN—Extension of the Operation for Cancer

T. EDWARD WILSON (Australia)—Anterior Resection of the Rectum

Cardio-Vascular and Thoracic Section

CLAUDE S. BECK—1. Operations for Coronary Artery Disease; 2. Resuscitation in the Operating Room

JACOB K. BERMAN—Mediastinal Enlargement

HOUCK BOLTON—Recent Advances in Cardiac Surgery

DENTON A. COOLEY—Surgical Considerations of Stenosing Esophagiitis

MICHAEL DE BAKEY—Extirpational Therapy of Aneurysms of the Aorta

JAMES H. FORSEE—The Surgery of Pulmonary Tuberculosis

FRANK GERBODE—Experiences with Diagnosis and Treatment in Cardiac Surgery of Infancy and Early Childhood

EMILE F. HOLMAN—Fundamental Principles in Arterial Repair and Reconstruction for Traumatic and Congenital Lesions

SEIJI KIMOTO (Japan)—Transplantation of Arterial Homo and Heterograft Preserved in Alcohol

ROBERT R. LINTON—The Results Obtained in the Treatment of 120 Patients with Bleeding Esophageal Varices by Portcaval Shunts

J. KEMPSON MADDOX (Australia)—Acquired Tricuspid Valve Disease: Medical Aspects

HORACE J. McCORKLE—Dissection of the Anterior Mediastinum for Metastatic Malignant Disease

HENRI P. P. METRAS (France)—The Surgical Treatment of the Complicated Forms of Primary Thoracic Tuberculosis

FRANK H. MILLS (Australia)—Surgery of the Tricuspid Valve

FREDERICK L. REICHERT—Revised Concepts of the Treatment of Raynaud's Syndrome and Thromboangiitis Obliterans

ALAN SHARP (Australia)—The Swollen Leg and Stasis Ulceration

HARRIS B. SHUMACKER, JR.—The Use of Pliable Plastic Tube for Bridging Aortic Defects

FRANCIS STOCK (Hong Kong)—Tumors of Blood Vessels

ALFONSO TOPETE (Mexico)—Surgical Management of Arterial Traumata and Use of Arterial Grafts

Obstetrical-Gynecological Section

A. LAURENCE BANKS—Vaginal Hysterectomy: Individual Variation in Technique and End Results

ROBERT H. BARTER—Current Concepts of Ovarian Surgery

WILLIAM T. BLACK, JR.—Culdoscopy

FRANZ BUSCHKE—The Place of Surgery and Radiotherapy in the Management of Cancer of the Cervix Today

RALPH E. CAMPBELL—The Diagnosis and Treatment of Enterocele

CARL HENRY DAVIS—Trichomonas Vaginalis Infections Incidence and Treatment with Carlendacide

FREDERICK H. FALLS—Pregnancy in the Bicornuate Uterus

PAUL FLETCHER—Abdominal Colpocystopexy for Complete Prolapse of the Vagina, Bladder or Uterus Utilizing the Rectus Suspension Principle of Crossed-Suspender Support

STANLEY T. GARBER—The Role of Vaso-depressor Drugs in the Treatment of Toxemia of Pregnancy

HUGH G. HAMILTON—The Metabolic Concept of Gynecological Care

D. FRANK KALTREIDER—Surgery in the Reduction of Perinatal Mortality

LEOPOLDO LOPEZ (Venezuela)—Considerations on Hysterectomy for Benign Lesions

LEON S. McGOOGAN—Choice of Anesthesia in Caesarean Section

JAMES H. MERING—A Surgical Approach to Intractable Pruritus Vulvae

DANIEL G. MORTON—Carcinoma-in-situ of the Uterine Cervix

FRANKLIN L. PAYNE—The Role of Radiation and Surgery in the Treatment of Corpus Cancer

HARRY A. PEARSE—Hospital Sterilization—Medical, Legal and Religious Aspects

JEAN P. PRATT—Diagnosis and Treatment of Endometriosis

L. M. RANDALL—Evaluation of the Trial of Labor

HOWARD C. STEARNS—Surgical Correction of Prolapsus Uteri. A Report on Selection of Operation and Results Obtained

IRVING F. STEIN—The Stein-Leventhal Syndrome

Otolaryngology Section

GEORGE W. BACHMANN, JR.—Pentothal and Local Anaesthesia for Tonsillectomy

JOHN CONLEY—1. One-stage Radical Resection of Cervical Esophagus, Larynx, Pharynx, and Lateral Neck with Immediate Reconstruction; 2. A New Technique for Facial Nerve Grafting in the Treatment of Tumors of the Parotid Gland

H. JAMES HARA—Malignant Tumors of the Paranasal Sinuses

CHARLES KINNEY—Changing Concept of the Surgical Management of Ear Pathology

PHILIP MacDONALD—The Newer Concepts in Rhinoplastic Surgery

A. A. MacGIBBON (New Zealand)—Tumors of the Ear

F. JOHNSON PUTNEY—Border-Line Malignant Lesions of the Larynx

SCOTT N. REGER—Newer Concepts of the Diagnostic Implications of Functional Hearing Tests

SAMUEL SALINGER—Surgical Correction of the Difficult Septum

GEORGE E. SHAMBAUGH, JR.—The Prevention of Post-Operative Serous Labyrinthitis after Fenestration

G. EDWARD TREMBLE (Canada)—Current Trends in Ear, Nose and Throat Therapy

Ophthalmological Section

MEACYR E. ALVARO (Brazil)—The Advantages and Disadvantages of Irradiation in Ophthalmology

ALFRED COWAN—The Role of the Pupil in Ametropia

WATSON GAILEY—An Old-Timer's Experience in 45 Years of Cataract Surgery

MARY E. KRAMER—Correlation of Refractive Procedures with the Orthoptic Treatment in Esotropia

WILLIAM E. KREWSON, III—Problems in the Diagnosis of Ocular Muscle Paralyses

LEO L. MAYER—Ophthalmic Surgery in the Veterans Administration

P. ROBB McDONALD—Changing Concepts in Retinal Detachment Surgery

WILLIAM P. McGUIRE—The Choice of Surgery in Chronic Glaucoma

SAMUEL J. MEYER—The Treatment of Cataract Surgery Complications

I. S. TASSMAN—The More Recent Aids in Ophthalmic Surgery

T. A'B TRAVERS (Australia)—1. Confusion, a Disadvantage of Binocular Vision; 2. Corneal Grafts in Australia

Urological Section

JAY J. CRANE—Prostatectomies and Open Resection of Median Bars and Contractures of Bladder Neck by Retropubic Approach

R. LEE HOFFMANN—One and One-Half Inches of Urology (Female Urethra)

LOWRAIN E. McCREA—The Importance of Vesical Innervation in Extended Pelvic Surgery

THOMAS R. MONTGOMERY—Ureterectasis—An Early Sign of Recurrent Rectal and Recto-Sigmoid Cancer

ARBOR D. MUNGER—Conservative Renal Surgery

D. K. ROSE—Analysis of Bladder and Related Renal Symptoms in Urinary Obstruction and Incontinence

DONALD R. SMITH—Hypospadias—Its Anatomy and Treatment

LUIS F. TORRES, JR. (Philippines)—One-Sitting Bilateral Kidney Operations

SAMUEL N. VOSE—Late Results of Ureteroenterostomy and Total Cystectomy

Orthopedics Section

CARL E. BADGLEY—The Surgical Approach to Recurrent Dislocation of the Shoulder

GEORGE K. CARPENTER—Internal Fixation in Conjunction with Bone Graft Surgery

PAUL C. COLONNA—My Present Ideas of the Colonna Hip Re-Construction Operation for the Un-United Hip Fracture

H. EARLE CONWELL—Conservative Surgery in Fracture Treatment

JOHN S. DONALDSON—Acquired Torticollis in Children and Young Adults

C. FRED FERCIOT—Evaluation of Prosthetic Replacement of the Hip Joint

JOSEPH A. FREIBERG—Desmoid Tumors of the Skeletal Muscles with the Report of Two Interesting Cases

KEENE O. HALDEMAN—Diagnosis and Treatment of Certain Traumatic and Degenerative Conditions of the Knee Joint

JULIAN E. JACOBS—Segmental Neuralgia and Backache

MERRILL C. MENSOR—Manipulative Treatment of Herniation of the Lumbar Intervertebral Disc and End Result Study

H. MINOR NICHOLS—Avulsion Injuries of the Upper Extremity

ROBERT G. PACKARD—The Role of Natural and Operative Fusion in Cases of Chronic Arthritis and in Allied Joint Conditions

LEONARD T. PETERSON—Fractures of the Hip: Treatment Including Prosthesis

PETER E. SABATELLE (Puerto Rico)—Costectomy and Mediastinotomy in the Treatment of the Paraplegia of Pott's Disease—Report of a Case

HOWARD B. SHORBE—Reconstruction of the Hip Joint: A Critical Evaluation of Some Earlier Methods

HAROLD A. SOFIELD—Multiple Osteotomies and Rearrangement of Bone Fragments for Osteogenesis Imperfecta and Congenital Pseudarthrosis

MARSHALL R. URIST—Newer Knowledge of the Treatment of Delayed and Non-union of Fractures

Neurosurgical Section

ROBERT A. GROFF

YOUNG SO KIM (Korea)—War Injuries on Peripheral Nerves in the Korean War

R. M. KLEMME—Brain Tumors—Operative Deaths

HUNTER J. MacKAY—An Improved Posterior Approach for Upper Thoracic Sympathectomy

HARRY P. MAXWELL—Angiography as a Diagnostic Tool

REX MONEY (Australia)—Angiography in the Management of Intra- and Supra-sellar Tumors

WILLIAM H. SWEET—The Uses of Nuclear Disintegration in the Diagnosis and Treatment of Brain Tumors

This is What's New!

Atabrine apparently may benefit **systemic** as well as discoid **lupus erythematosus.** The suggested starting dose of atabrine was 300 mg. a day for the first week. Doses as large as 2,000 mg. a day for two months were used. In general, the less acute or discoid form of the disease responded better than the systemic form. Other antimalarial drugs, namely chloroquine and quinine, were used in a smaller series with follow up over a shorter period of time. The author has also observed that atabrine completely inhibits the LE phenomenon in vitro. [Dubois, E.L., *A.M.A. Arch. Int. Med.* 94:131 (July) 1954.]

* * *

S. H. Flowerman, Director of Research, Postgraduate Center for Psychotherapy in New York, discourses on the **major myths in psychotherapy.** The most dangerous and probably the most prevalent is the myth of the W.A.M., the legendary "well-analyzed man." The W.A.M. is a rather grey bird who does not get too euphoric or depressed, has no psychosomatic illnesses and avoids all accidents. The W.A.M. is, of course, usually the therapist, rather than the patient. His concluding plea, "If only the psychotherapeutic myths of omnipotence, omniscience and infallibility could be dispelled by humility and self analysis!" [*Texas Rep. Biol. & Med.* 12:260 (Summer) 1954.]

* * *

Cardiac arrest during surgery is usually due to **anoxemia** resulting from poor ventilation or failure to maintain circulating blood volume. Thoracotomy with cardiac compression, if to be successful, should be performed within three minutes after cardiac arrest. [*J.A.M.A.* 155:709 (June 19) 1954.]

* * *

The extensive use of **Alcoholics Anonymous** by **problem drinkers** in one large industry resulted in a 65 per cent rehabilitation over a ten-year period. T. H. Hogshead, of duPont's medical division, also mentions that no alcoholics are accepted for treatment in their psychiatric section until they have stopped drinking. Alcoholism is apparently recognized as a major problem in industry by the top echelon. At one AA meeting in Wilmington were present—as visitors—the Chairman of the board, Vice-President and ten general managers of the duPont company. [*A.M.A. Arch. Indus. Hygiene & Occup. Med.* 9:526 (June) 1954.]

* * *

The **absorption of B12 taken orally** is **inversely proportional to the dose.** By tagging B12 with radioactive cobalt, it was found that the counts taken over the liver actually decreased as more vitamin B12 was ingested. This is attributed to a mucosal block which is almost a complete block in pernicious anemia and sprue. This can be converted to a partial block by the administration of intrinsic factor from human or hog stomach along with the B12. [*Science,* 120:74 (July 9) 1954.]

* * *

Hydrocortisone activity can be boosted by substitution of a halogen atom in the nine-alpha position. This **chloro-F acetate** was found to be about **eight times as active as hydrocortisone** in inducing eosinopenia and is also more active in glycogen deposition and sodium retention than either cortisone or hydrocortisone.

Also reported at the Endocrine Society meeting in San Francisco, June, 1954, was the correction of **malignant exophthalmos** by **transection of the pituitary stalk** after unsuccessful orbital decompression. Two and one-half months after an unsuccessful bilateral orbital decompression, a second craniotomy was performed and it was noted that the pituitary stalk was hypertrophied. The stalk was severed and rapid improvement in the exophthalmos occurred over the next two weeks. [*J. Clin. Endocrinol. & Metabolism* 14:830 (July) 1954.]

At the same meeting W. Wolfson, et al., reported that patients treated continuously with **corticotropin** for from three and one-half to five years show **no evidence of pituitary injury.** They did advise sodium restriction and potassium administration.

FRED I. GILBERT, JR., M.D.

Woman's Auxiliary

The Hawaii Medical Association has acknowledged that the recent post-American Medical Association Convention tour was a notable success. The Woman's Auxiliary helped contribute to that success by providing an information and hospitality desk at the Royal Hawaiian Hotel during the first four days of the tour. Mrs. Frederick L. Giles was chairman of the project, assisted by Mrs. Thomas F. Fujiwara. Members of the Auxiliary acted as hostesses at the desk.

The Auxiliary also staged a fashion show luncheon at the Halekulani Hotel attended by some two hundred and thirty-five visiting and local doctors' wives. Especially honored guests were four past presidents of the National Woman's Auxiliary to the American Medical Association: Mrs. Eustace A. Allen, Atlanta, Georgia; Mrs. A. A. Herold, Shreveport, Louisiana; Mrs. David W. Thomas, Lock Haven, Pennsylvania; and Mrs. Frank Gastineau, Indianapolis, Indiana, who is now National Auxiliary Chairman of the American Medical Association Education Foundation. Also honored was Mrs. Robert Flanders, Manchester, New Hampshire, First Vice-President of the National Auxiliary.

Fashion show chairman was Mrs. Philip S. Arthur; co-chairman in charge of the luncheon was Mrs. Robert G. Johnston. Mrs. Elaine North of United Airlines acted as fashion show commentator. Models for the event were wives and children of Honolulu doctors, with fashions contributed by Watumulls. Hawaiiana was the fashion show theme as the ensembles shown were designed and made in the Islands.

Mrs. William John Holmes, as chairman of the Auxiliary's newly-formed Aloha Committee, was called upon to assist the welcoming committee at the airport. A hundred orchid leis, donated by the Hawaiian Flower and Lei Exchange, were presented by the Medical Association to prominent mainland medical guests arriving on chartered planes. The Aloha Committee has been organized to extend our Hawaiian hospitality and greet incoming visitors Hawaiian style.

AUXILIARY OFFICERS for the YEAR 1954-55

The Woman's Auxiliary to the Hawaii Medical Association

Mrs. Ralph B. Cloward ..... *President*
Mrs. William John Holmes ..... *President-Elect*
Mrs. K. S. Tom ..... *First Vice-President*
Mrs. Edmund Tompkins ..... *Second Vice-President*
Mrs. A. L. Vasconcellos ..... *Recording Secretary*
Mrs. Dorian Paskowitz ..... *Corresponding Secretary*
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Mrs. Harold Kushi ..... *Recording Secretary and Treasurer*

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Mrs. L. L. Buzaid

Bureau of Medical Economics

"Information Please"

Name..... Spouse's Name.....

Address..... Phone.....

Employer..... Bank.....

Reference:.....

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Nearest Relative:.....

Have you ever applied for credit? More than likely you have, and you have given the above information without hesitation. Is it not true that 95% of your patients have applied for credit with you? Do your records have this information?

Our files here at the Bureau of Medical Economics indicate that you are not receiving this valuable information. People do not resent questions which help them establish their credit—they welcome them. They appreciate a pre-arranged payment plan. Medical accounts, certainly if over $100.00, should come in the credit category.

"Nobody lives in a mail box," yet month in and month out the Bureau receives scores of assignments with no other information other than, "Mr. or Mrs. Lee, P. O. Box, Honolulu." To trace this account is almost impossible. Home calls for collection are completely impossible. There are no neighbors to check, no cars to watch, just a cold trail.

Next time a patient gives a P. O. Box or any other vague address to your secretary, have her say: "Thank you Mr. Lee, but I wonder if you could give me the number and street of your house, in case the doctor may have to make a house call for you. It might save much valuable time in an emergency." If they refuse, there must be a reason . . . watch out for them.

Our records here at the Bureau, with over 3200 individual accounts, are showing a very solid trend with regard to the value of the account in relation to its age. The accounts remain rather stable until they reach the six month level, at which time they take a tumble in value. Then at twelve months they really drop in the percentage collectable. Remember that these are figures from medical accounts in Honolulu not a national retail average, or a national medical average, but an average of the Honolulu doctors. The Bureau strongly recommends that an account that you have had no contact with in five months be turned over for collection, and that you in no case keep one in your files past the eleven month old level, (We are speaking of accounts which you have had absolutely no contact with in the periods mentioned).

Hints for your Public Relations

1. Establish clear financial understanding prior to treatment or billing if the amount is to be over $10.00.
2. Determine the patient's actual ability to pay, not merely his willingness to agree to a financial obligation because he is ill and needs care at that time.
3. Charge no more than the patient is well able to pay and make specific arrangements for the method of payment. These suggestions are not "commercialistic"; they are the opposite. It is unfair and dishonest to place a patient under a financial obligation about which he does not have a full knowledge.
4. Inform the patient of his obligation to pay for other services: laboratory, consultant, assistant, x-rays, anesthesia, and so forth.
5. Bill regularly and itemize all statements.
6. Get full information regarding the patient at the time of the original interview: full name, responsible party, where employed, kind of work, home and business address and phone number, insurance coverage, name and occupation of spouse.
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RICHARD M. KENNEDY
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In the summer and fall of 1953, nine prominent allergists, representing every section of the country except the West Coast, tested Pyribenzamine in a total of 832 patients with ragweed hay fever. The work of these men is significant because of its scope and because it is the most recent major study of antihistamines.

Certain observations are particularly worth noting . . . →



(PHOTOGRAPHS FROM A STUDY CONDUCTED BY CIBA)

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BILATERAL ARTERIOSCLEROTIC ULCERATION in patient age 65. At start of Priscoline therapy; ulcer, right leg, 1¾″ x 1¼″; ulcer, left leg, ½″ x ½″. With oral Priscoline, 25 mg. four times daily for one week and 25 mg. every three hours thereafter, there was marked improvement in 2 weeks and healing within 6 weeks. No other medication given.

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PHOTOGRAPHS AND CLINICAL DATA BY COURTESY OF R. I. LOWENBERG, M.D., CONSULTANT IN VASCULAR SURGERY, CONNECTICUT STATE HOSPITAL, MIDDLETOWN, CONNECTICUT.

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Perhaps It's Your Nerves

Some Psychodynamic Aspects of Alcoholism

Chronic alcoholism has forced itself more and more into scientific view because of the extreme individual and social disability which accompanies it. It has become the concern of the minister, the police officer, the sociologist, the internist, the social worker, the psychologist, the physiologist, the employer and the psychiatrist. The general public has its own attitudes and reactions to the problem. Out of a tremendous number of studies, and of attempts to approach alcoholism effectively, has come surprisingly little constant material. The mere observation that there are so many theories and approaches to the treatment of alcoholism also indicates the lack of specific knowledge.

We have learned that there is no such thing as a specific dynamic structure of the alcoholic personality. Also, we have learned that there is no one specific treatment for alcoholism in its chronic stages. There are, however, certain recurrent themes and factors which run throughout the research that has been done. These recurrent factors give us a common starting point in terms of their consistent reappearance in various studies with various investigators.

Chronic alcoholics group themselves into three types, most commonly described as the essential, symptomatic, and reactive. As one might surmise, "essential" refers to the person whose chronic alcoholism seems to be the main neurotic manifestation of a maladjusted personality; "symptomatic" refers to the situation in which the chronic alcoholism is one of several symptoms secondary to an underlying neurosis or psychosis; "reactive" implies a severe alcoholism due to a specific life-situation which is being specifically reacted to by the symptom of excessive drinking. An interesting article by Earl Schaefer appeared in the June issue of the *Quarterly Journal of Studies on Alcohol,* in which he described five types of alcoholics. He divided them into the "schizoid or inadequate" group, the "anxious" group, the "unstable" group, the "psychoneurotic" group and the "relatively normal" group. The type which most of us are concerned with and which presents the greatest problem to society is that described most commonly as the "essential" type of alcoholic.

One of the most frequent undercurrents in the alcoholic personality is a feeling of social inadequacy. They do not feel able to compete or hold their own in a group or their community. Associated with this is a life-long struggle for prestige. The need to establish this prestige in their own eyes and in the eyes of others is so important that it may be symbolically representative of a life-or-death struggle.

In spite of the tremendous need for prestige and social adequacy, the alcoholic is usually a basically severely dependent person who has felt himself to be severely deprived of affection and security since early childhood. An alcoholic has often had a very close relationship with the parent of the same sex, who is usually a rather strong personality. The frequent result of this relationship is that the child takes a passive position and does not find himself able to rebel or to compete with this parent. The relationship with the parent of the opposite sex is usually a more mixed one, with the tendency for the men to feel that their dependency needs have been frustrated somewhat by their mother, and to react in a hostile way to this.

This family relationship seems to foster an attitude on the part of the patient that society demands perfection, superiority, and blamelessness from him. This unrealistic and impractical view inevitably leads him to feelings of inadequacy, since none of these traits can be actually achieved.

Another result of the frustration of dependency needs and the fear of the strong parent is that much hostility and resentment is developed around the great demands of society as well as around those of the parents. The alcoholic fears his own aggressive feelings, since he does not feel that he can win in any competitive struggle. He also fears these feelings because they run counter to his strongly developed punitive conscience: the implication is that if he behaves in a hostile-aggressive way then he will be severely punished in some way; therefore, he is forced back into an outwardly passive position in relationship to other people. These people tend to fluctuate from unnecessarily extreme passivity to unnecessarily extreme aggressiveness.

Much attention has been called to the self-punitive aspects of chronic alcoholism, and this has been generally related to the above-mentioned fear and consequent guilt over hostile feelings. Thus, alcoholism can often serve the double purpose of being a hostile act to hurt others and a hostile act to hurt the self at the same time.

Sexually, the alcoholic is immature; he has characteristically an inhibited sexual life. There is usually a lack of tenderness and, as could be expected, a strong feeling of sexual inadequacy.

The drinking itself seems to serve many purposes. Superficially, the person drinks to change his mood and his feeling. On a deeper level, it appears that the alcoholic is able to give himself more esteem and to feel more esteemed by others while drinking. With this increase in self-esteem he feels stronger and more able to give vent to his hostility and his need for rebellion, as mentioned above. The act of drinking also symbolically represents affection and gratification of primitive oral (nutritive) needs.

The feeling of euphoria which comes early in the alcoholic bout tends to change to a later depression with increasing awareness of the artificial psychological situation he is trying to create and the fact that he is not actually deserving of admiration as he had phantasied it before. It is apparent that the combination of basic social inadequacy feelings plus the effects of the severe alcoholic bout inevitably will lead the alcoholic to greater feelings of being a "worthless outcast," and these feelings may be equally severe, or more so, after the particular alcoholic episode is passed.

It is characteristically difficult to pin down the situation or group of situations which seem to begin the chronic alcoholism. One reason for this problem is that the personality difficulties of the alcoholic make him usually unable to tolerate the chronic tension that even *ordinary* living imposes. Thus, the daily stress of independent adult behavior makes too many demands upon the specific weaknesses of this person's psychological structure.

The inevitable reaction of the alcoholic's family, his employers and society as a whole to him and his behavior tends to drive him further into his problem and into his feelings of worthlessness and inadequacy. The actual realistic basis of some of this rejection makes the problem most difficult to work with and develops a "circular" type of reaction between the alcoholic and his environment. The repeated failures of the alcoholic in his attempts to adjust are characteristic and understandable in the light of some of the features mentioned above and in the light of his basic fears of success. Many of these people develop increasing anxiety as they come closer to succeeding in an independent adjustment. This increase in anxiety frequently is the stress which sends them back into another alcoholic bout and certain failure.

The treatment of chronic alcoholism is a most difficult and poorly understood undertaking. As might be expected, these people generally respond very poorly to threats and coercion, although this is the natural tendency of the community in their contact with a severe chronic alcoholic. These patients not only need help with their individual emotional, physical, physiological and social problems, but they need help in such great quantities that it is almost impossible to supply it.

One of the most effective approaches to the treatment of chronic alcoholism has been through skilled use of a social group as a therapeutic medium. This group should offer diminished competitiveness and increased emotional support. The general eventual goals are those of building self-esteem, social adequacy, independence, and realistic views of their own capabilities and liabilities, so that practical planning for their own lives may be done.

The most effective work with alcoholics, after the acute stage, has been done in out-patient settings, particularly out-patient settings with group experience as mentioned above. Alcoholics Anonymous has probably had more successes than any other specific approach. They have utilized many of the principles stated here. Much of their effectiveness is probably also due to the sense of esteem felt by the patient when he finds that he is participating in a program and is helping others, thus being a useful member of a group for the first time since his severe alcoholic episode began. Skilled use of social group work techniques will be of great value in meeting this present problem, and it is hoped that there will be increasing emphasis placed on this in the training centers where therapeutic group work is being developed.

The understanding of the alcoholic is a complex and individual matter. The treatment of chronic alcoholism is a long-term project which involves much time, energy, and many disappointments. The percentage of cures is relatively small. Chronic alcoholism is such a severe social problem, however, that communities should see to it that adequate funds and facilities are provided to deal with it, since the problem needs specific attention.

ROBERT A. KIMMICH, M.D.

The Honolulu County Medical Library

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Monday through Friday
Closed Saturdays at noon and Sundays
Closed all day and evening on National holidays
and at noon on Territorial holidays

Recent Acquisitions

Atomic Medicine

Feinberg, J. J. *The atom story.* 1953. (gift of publisher).
Laughlin, J. S. *Physical aspects of betatron therapy.* c1954. (gift of publisher).

Biochemistry

Luck, J. M., ed. *Annual review of biochemistry.* v.23. 1954.

Cancer

Farber, S. M. *Lung cancer.* c1954. (gift of publisher).

Cardiology

Child, C. G. *The hepatic circulation and portal hypertension.* c1954. (gift of publisher).
Dimond, E. G. *Electrocardiography.* c1954 (gift of publisher).
Edwards, J. E. *An atlas of congenital anomalies of the heart and great vessels.* c1954. (gift of publisher).
Texon, Meyer. *Heart disease and industry.* c1954. (gift of publisher).

Clinical Medicine

Cutting, W. C., ed. *Annual review of medicine.* v.5. 1954.
Gladston, Iago, ed. *Beyond the germ theory.* c1954. (gift of publisher).
Grollman, Arthur. *Acute renal failure.* c1954. (gift of publisher).
Horder, Lord. *Fifty years of medicine.* 1954. (gift of publisher).
Lukens, F. D. W., ed. *Medical uses of cortisone.* c1954. (gift of publisher).
Smith, Austin, ed. *Modern treatment: a guide for general practice.* c1954. (gift of publisher).

Endocrinology

Paschkis, K. E. *Clinical endocrinology.* c1954. (gift of publisher).
Simmons, F. A. *The diagnosis and treatment of the infertile female.* c1954. (gift of publisher).

First Aid

Fine, Jacob. *The bacterial factor in traumatic shock.* c1954. (gift of publisher).
Roskam, Jacques. *Arrest of bleeding.* c1954. (gift of publisher).

Leprosy

McNarney, M. A. *Kalawao.* c1954.
Memoria de la Tercera conferencia Panamericana de leprologia. Tome 1. 1953. (gift of Dr. Arnold, Jr.).

Neurology & Psychiatry

Haymaker, Webb. *Peripheral nerve injuries.* 2nd ed. c1953. (gift of publisher).
Solomon, J. C. *A synthesis of human behavior.* c1954. (gift of publisher).
Wolstein, Benjamin. *Transference.* c1954. (gift of publisher).

Nursing

Brown, A. F. *Clinical instruction.* c1949. (from Nurses' Association).

Ophthalmology & Otolaryngology

Boies, L. R. *Fundamentals of otolaryngology.* 2nd ed. c1954. (gift of publisher).
Duke-Elder, Sir Stewart. *Textbook of ophthalmology.* v.6. 1954.
Pascal, J. I. *Optometrists' handbook of eye diseases.* c1954. (gift of publisher).

Orthopedics

Dubuisson, M. *Muscular contraction.* c1954. (gift of publisher).
Liebolt, F. L. *Illustrated review of fracture treatment.* c1954. (gift of publisher).
Moseley, H. F. *Shoulder lesions.* 2nd ed. rev. & enl. c1953. (from Board of Medical Examiners).

Pathology

Moore, R. A. *A textbook of pathology.* 2nd ed. c1951. (from Board of Medical Examiners).

Pediatrics

Michal-Smith, H., ed. *Pediatric problems in clinical practice.* c1954. (gift of publisher).
Shirley, H. F. *The child, his parents and the physician.* c1954. (gift of publisher).

Tropical Medicine

Wolff, J. W. *The laboratory diagnosis of leptospirosis.* c1954. (gift of publisher).

During the past few months, the Library has prepared and sent out shipments of over 5,000 duplicate journals to medical libraries all over the world. One such shipment was sent to a library in Sweden, and Mr. Gustaf Olson, the Swedish Consul, was kind enough to arrange to have it picked up by a Johnson liner on her way home to Sweden. We were also grateful for the assistance of Dr. Duke Cho Choy in the selection and packing of a large shipment of books and journals for Korea.

Through correspondence relative to such MLA and UNESCO exchanges, we have been fortunate in working out mutually beneficial agreements with medical libraries in Sweden and Portugal. We have arranged to exchange current issues of some of the important foreign journals for duplicates of state journals received here. Though the work involved in handling such shipments is arduous and time consuming, we feel that our efforts are well rewarded—not only because our collection is enriched and developed, but equally important, cordial international relationships are established and maintained.

Book Reviews

Nine Doctors and God.

By F. J. Halford, M.D., 336 pp., Price $4.00, University of Hawaii Press, 1954.

Seventy-eight years of Hawaiian history—from the arrival of Dr. Thomas Holman with the First Company of Missionaries in 1820 to the death of Dr. Charles Wetmore in 1898—are recounted by Dr. Halford through the eyes of the nine doctors sent to Hawaii by the American Board of Commissioners for Foreign Missions between 1820 and 1848.

Though all except Wetmore came as official members of Missionary Companies, only two—Dwight Baldwin and Thomas Lafon—were ministers. None of the others seem to have been very strongly identified with the religious purposes of the enterprise, and indeed the first two, Dr. Holman and Dr. Abraham Blatchely, left before their replacements arrived, the former because of irreconcilable differences with the missionary group, which led to his excommunication, and the latter because of his health.

The outstanding figure among the nine was the third one, Gerrit Parmele Judd, who came in 1827 and resigned in 1842. Physician, statesman, teacher, and patriarch, his life would, as the author says, make a book in itself. Among his distinctions was that of founding a medical school in Hawaii, in 1871.

Dwight Baldwin, the fourth of the nine, and one of the two who were ministers as well, practiced here for over 30 years before receiving his medical diploma, which he had earned at Harvard in 1830. He devoted a great deal of his time and effort to the natives' spiritual needs as well as their illnesses.

The book goes on through the careers of Alonzo Chapin, a versatile and articulate scholar; Thomas Lafon, minister, ardent abolitionist, and Hawaii's first plantation physician (at Koloa); Seth Andrews, naturalist; James Smith, and finally Charles Wetmore, whose daughter Frances became Hawaii's first woman physician.

An appendix contains excerpts from Chapin's *Climate and Diseases of the Sandwich Islands*, published in 1838, and Lafon's inaugural thesis, *The Utility of the Bandage*, 1827. There are biographical notes on seven nonmissionary doctors of the period: Rooke, Wood, Ford, Hillebrand, Trousseau, Hoffman and Emerson. A chronology, population tables, a glossary of Hawaiian words and a detailed bibliography of source material, much of it unpublished, complete the book.

There are portraits of most of the doctors and some of their wives, and the pages are enlivened by numerous "spot" line drawings by Keichi Kimura. End papers show a map of the Islands depicting the sites of the missionary stations.

As Dr. Nils P. Larsen, "Pete" Halford's long time friend and professional associate, says in his preface to the book, "*Nine Doctors and God* is . . . the rare achievement of scholarly research presented in a lively manner. It constitutes a splendid memorial to a tenth doctor who lives throughout the book and was taken in his prime from the islands that he loved."

HARRY L. ARNOLD JR., M.D.

Illustrated Review of Fracture Treatment.

By Frederick Lee Liebolt, A.B., M.D., Sc.D., LL.D., 229 pp., illustrated, Price $4.00, Lange Medical Publications, 1954.

Although the most appealing thing about this publication is its price, it might well serve as a primer of fracture therapy for the intern and resident. (Not to forget the practicing physician who is unable to refer his cases to a competent orthopod).

Illustrations are profuse and well done; therapy in each case is neatly and simply outlined, with emphasis on the conservative rather than operative management.

In the library it will serve as another good dust collector, but in the emergency room, where it belongs, it would be referred to daily and with benefit to both patient and doctor.

JOHN W. HOWARD, M.D.

The Child, his Parents and the Physician.

By Hale F. Shirley, M.D., 159 pp., Price $3.75, Charles C. Thomas, 1954.

The author, a pediatrician–child psychiatrist, presents a practical approach to the basic emotional and behavior problems of childhood. The entire subject matter is covered in simple, non-technical terms—a much desired characteristic lacking in most psychiatric textbooks which waste a lot of print in defining terms used or which keep the reader constantly referring to a dictionary. No effort is made in describing methods of psychotherapy.

This book should be of practical value for those who constantly work with children — parents, physicians, teachers, nurses, ministers, social workers and others.

C. K. KOBAYASHI, M.D.

The Hepatic Circulation and Portal Hypertension.

By Charles G. Child, III, M.D., 444 pp., illustrated, Price $10.00, W. B. Saunders Company, 1954.

This monograph exhaustively summarizes all the literature on the subject, of both historical and current interest. At times too much emphasis is placed on the recitation of the many small contributions made over the previous two or three hundred years, contributions no doubt important at the time but long since submerged by more precise and valid observations.

After a prolonged review of the embryology, anatomy and physiology of the hepatic circulation, there is a lucid but disappointingly brief discussion of the clinical problem of portal hypertension. The material is drawn from the records of the New York Hospital and covers the treatment of 34 cases by various types of procedure. The results of important pre- and post-operative metabolic and physiological studies on these patients are recorded. The appendix records in detail many experiments, carried out by the author and his associates, on which are based the principles they have followed in handling clinical problems.

This book will be of great value to those interested in this special topic but will have a very limited usefulness to the average practicing physician.

G. C. FREEMAN, M.D.

Clinical Endocrinology.

By Karl E. Paschkis, M.D., Abraham E. Rakoff, M.D., and Abraham Cantarow, M.D., 830 pp., illustrated, Price $16.00, Paul B. Hoeber, Inc., 1954.

It is not often that one finds a book on so complex a subject as endocrinology as understandable as this. The authors have very effectively outlined the physiology of the gland being discussed, and then integrated it into a discussion of the various disease entities and therapy. I can wholeheartedly recommend this book to anyone needing information on diagnosis and treatment of any subject in endocrinology.

RAYMOND M. DEHAY, M.D.

Neurosurgery of Infancy and Childhood.

By Franc D. Ingraham, M.D. and Donald D. Matson, M.D., Second Edition, 456 pp., 482 illustrations, Charles C. Thomas, 1954.

This welcome addition to the neurosurgical literature covers the subject within the scope set by the authors. As noted in the preface, the book is a description of the methods of diagnosis and techniques of patient care which have been developed or found most useful to date at The Children's Medical Center, Boston. Within this limited scope the methods used are fully described. The results of treatment of the various neurosurgical conditions in this age group by these methods are tabulated and throughout the book the rationale of the therapy is explained.

For the non-specialist the many excellent photographs present the problems with a clarity words could not accomplish. The large clear print and the concise style make reading easy and rapid. The book is highly recommended for anyone interested in pediatrics and neurosurgery.

JOHN J. LOWREY, M.D.

Pediatric Problems in Clinical Practice.

Edited by H. Michal-Smith, Ph.D., 310 pp., Price $5.50, Grune & Stratton, Inc., 1954.

The title of this book is misleading. It suggests a handy reference book which would deal with the more common every day problems in a clinical practice. This, however, is not the case. In fact, having read this at times interesting book, it is not clear to me just for whom it was written. Parts will be of interest and value to the physician, some to the occupational therapist, some to the social worker, etc.

There are 13 chapters, one about the "normal" child, with the remaining 12 each devoted to discussions of a specific type of handicapped child. Each one is written by a recognized expert in that particular field. There is considerable repetition, as would be expected in this type of book, particularly from the standpoint of methods of taking histories and doing physical examinations. A great deal of time is spent in each case on theories, definitions and explanations of phenomena and, in several chapters, references are made to the fact that there are advances in therapy such as in physiotherapy, occupational therapy, surgery, etc., but no mention as to what these advances are. I was much impressed by the over-emphasis on theory and the paucity of practical diagnostic and therapeutic discussion.

D. H. MURRAY, M.D.

Fundamentals of Otolaryngology.

By Lawrence R. Boies, M.D., Second Edition, 487 pp., Price $7.00, W. B. Saunders Company, 1954.

This newest of the otolaryngology text books is by a group of authors. It is very current and in general well balanced. Although it deals in basic concepts there are complete bibliographies on each chapter. The newer procedures such as rhinoplasty, the use of ACTH and cortisone are covered and an excellent chapter for such a basic book on hearing losses and audiology.

The print is clear and the paper of good quality. One criticism for island practitioners is its very brief treatment of nasal and respiratory allergies. However, the book is very worthwhile to specialist and general practitioner. Detailed prescriptions and treatment techniques make it a valuable contribution to any library.

JOHN P. FRAZER, M.D.

The Treatment of the Alcoholic.

By Fritz Kant, M.D., 130 pp., Price $3.50, Charles C. Thomas, 1954.

This small volume by Dr. Fritz Kant is a practical compendium of clinical knowledge about alcoholism which gives one a quick survey of the essential facts as most of us know them. It presents these facts in a well organized manner, is reasonable in its viewpoint, and practical, and one finds oneself in agreement with all of the statements which are made. For the experienced psychiatrist it is a worthwhile quick review. For the general medical man it presents a good deal which he already knows, but also additional medical facts derived from specialization. It is written simply so that it has value for the layman who wishes orientation to the problem of alcoholism.

This book is recommended as an easily read volume which gives one a practical perspective in this very difficult field of medical treatment.

J. ROBERT JACOBSON, M.D.

The Optometrist's Handbook of Eye Diseases.

By Joseph I. Pascal, B.S., M.A., O.D., M.D., and Harold G. Noyes, A.B., A.M., M.D., 300 pp., illustrated, Price $9.50, C. V. Mosby Company, 1954.

Doctors Pascal and Noyes have condensed a lot of ophthalmology into 282 readable pages. Illustrations are excellent and the subject matter lucidly presented. The authors preface their book with the thought that optometrists, who are often the first to come in contact with a patient, should be well grounded in fundamentals of medicine.

With the above concept, the reviewer is in hearty agreement. The authors, however, go beyond diagnosis and discuss treatment, surgery, drugs, rare syndromes, etc. It is doubtful that optometrists are adequately grounded, or need, to understand such detailed discussion of applied subjects.

There is an excellent and detailed chapter on "Helps for Blind and Near Blind."

Controversial and doubtful subjects are discussed, such as the relationship of glaucoma and myopia, the endocrines, hypothyroidism and myopia, the role of the spleen in the etiology of glaucoma, etc. The reviewer doubts the value of discussing controversial subjects in a book of this sort.

O. D. PINKERTON, M.D.

Cure Your Nerves Yourself.

By Louis E. Bisch, B.A., M.D., Ph.D., 247 pp., Price $3.50, Wilfred Funk, Inc., 1953.

This book attempts to cure the patient with "nerves" by suppressive techniques. The author, a psychiatrist, who has written many similar books and conducts a mental health column in newspapers and magazines, makes a deliberate attempt to meet a patient's need for a strong, firm, guiding, controlling hand. He aims to strengthen the patient's defenses against anxiety by authoritative firmness and commands. For example, some of the titles of the chapters are "Feelings of Guilt Must Be Banished," "Don't Let Self Consciousness Deceive You," "Trying to Escape Reality Gets You Nowhere," etc. In part also, this book tries to counteract the secondary benefits of neurotic illness, such as striving for attention and sympathy and the use of symptoms to control the environment.

This book could be advantageously used by those patients who are relatively mature individuals in reactive upsets largely based on extraordinarily severe environmental pressures. For others, any improvement will probably only be transient as no fundamental change in adjustment can be brought about by this technique. The technique used in this book is purely supportive and leaves the basic problems unsolved, and thus the patient remains very vulnerable to the inevitable subsequent stresses and strains of living.

PERSHING S. LO, M.D.

Menorrhalgia: Menstrual Distress.

By William Bickers, M.D., 97 pp., Price $2.75, Charles C. Thomas, 1954.

This is a monograph in American Lectures in Gynecology and Obstetrics by an author who since 1942 has studied and written numerous papers on menorrhalgia.

Menorrhalgia is defined by Dorland's Medical Dictionary as dysmenorrhea, but the author includes under this term all the symptoms related to menstruation and classifies under menorrhalgic triad, dysmenorrhea, premenstrual tension and pelvic vascular congestion.

The physiology and endocrinology relative to menstruation and his concept of the "why" of menstrual distress are discussed. The various products and methods of therapy utilized at present and his mode of treatment are outlined, but very little new material is evident.

EDWARD T. MATSUOKA, M.D.

Atlas of Orthopedic Traction Procedures.

By Carlo Scuderi, B.S., M.D., M.S., Ph.D., 230 pp., illustrated, Price $12.50, C. V. Mosby Company, 1954.

To my knowledge, this atlas is the only one of its type, and for a long time the practicing orthopod, but more especially the teacher and resident physician, has been sorely in need of just such a reference. The clear cut photographs and schematic illustrations accomplish on one page what a thousand words in the lecture room would do, and with much less chance of error and confusion.

Beginning with the basic materials such as the orthopedic bed, mattress, and overhead frame, all practical forms of traction are illustrated and accompanied by a short and practical discussion of the merits and pitfalls in each case.

A few moments spent with this book would be well worth the effort of any physician engaged in the frequent or even occasional treatment of fractures.

JOHN W. HOWARD, M.D.

The Obstetrical Forceps.

By L. V. Dill, M.D., F.A.C.S., 156 pp., illustrated, Price $5.25, Charles C. Thomas, 1953.

This monograph presents a clear and concise discussion of the obstetrical forceps from the time of its invention to its use at the present. The book describes and illustrates in detail the mechanisms of the forceps and different methods of forceps application, traction, and rotation in both normal and abnormal presentations. Special forceps, such as Tarnier, Kjelland, Barton and Piper forceps, are discussed in separate chapters. The chapter discussing the choice of specific forceps for specific indications is logically conceived.

A well written book with large print, good paper and profusely illustrated with photographs and drawings.

K. S. TOM, M.D.

Peripheral Nerve Injuries.

By Webb Haymaker, M.D. and Barnes Woodhall, M.D., Second Edition, 333 pp., illustrated, Price $7.00, W. B. Saunders Company, 1953.

This useful book is a very thorough and painstaking analysis of peripheral nerve injuries. It gives a detailed analysis of the anatomy of the peripheral nerves as an explanation of the symptomatology which is dealt with later. The examination of the patient is described for each individual nerve and plexus injury. The trick motions patients can use to confuse the examiner are all described. Anyone with any type of peripheral nerve injury should get some help from the book by referring to the proper section.

The book is amply illustrated with drawings, photographs and charts. This is a book to refer to for the individual case. There is too much detail, some of it in small print, to make the book readable.

JOHN J. LOWREY, M.D.

A Manual of Tropical Medicine.

By Thomas T. Mackie, M.D., George W. Hunter, III, Ph.D., and C. Brooke Worth, M.D., Second Edition, 907 pp., illustrated, Price $12.00, W. B. Saunders Company, 1954.

Quite by chance, I opened this book on page 127, and a sub-heading misspelled "Haverill" Fever caught my eye. It is spelled correctly in the text, but is also misspelled on page XV of the Contents and on page 875 of the Index. This is the only misspelling noticed in the book.

This is a manual and is solid meat. It gives concisely the practical aspects of the more important tropical diseases in all phases, from epidemiology, laboratory diagnosis, treatment, control and prophylaxis and contains the Army medical experience gained in Korea. It has brought the obsolete 1945 edition up to date. Fish poisoning is barely mentioned and should be given a few lines. There is no mention of Wood's light in diagnosis of tinea capitis. The use of the sweating test in diagnosis of leprosy is simple and valuable in pigmented races and should have more mention than "seldom used."

The 854 pages of packed text leave no room for bibliography. This library in one book is surprisingly light and of moderate size. I highly recommend it to any physician interested in tropical medicine. The 304 illustrations are for the most part, outstanding.

JAMES R. ENRIGHT, M.D.

An Atlas of Congenital Anomalies of the Heart and Great Vessels.

By Jesse E. Edwards, M.D., Thomas J. Dry, M.S. in Medicine, Robert L. Parker, M.D., Howard B. Burchell, M.D., Earl H. Wood, M.D., and Arthur H. Bulbulian, D.D.S., Second Edition, 202 pp., illustrated, Price $13.50, Charles C. Thomas, 1954.

The authors—all of the Mayo Clinic and Mayo Foundation for Medical Education and Research—have revised and enlarged their first *Congenital Anomalies of the Heart and Great Vessels* (1948). Data obtained by study of patients by such techniques as cardiac catheterization, oximetry, dye-dilution methods and intra-arterial pressure studies have been included. All reproductions of photographs, models, diagrams, etc. in color or in black and white are excellent. Principal clinical features of each anomaly are clearly and briefly outlined. The inclusion of endocardial sclerosis (fibroelastosis) in a book of congenital anomalies of the heart is interesting.

The book is an excellent addition to Taussig's classic as an easy reference book.

C. K. KOBAYASHI, M.D.

Electrocardiography.

By E. Grey Dimond, M. D., 261 pp., illustrated, Price $14.00, C. V. Mosby Company, 1954.

This book, the outgrowth of five years of classroom teaching, is written for the general practitioner and medical student, but it will serve as an excellent reference for those more deeply interested in interpretations of electrocardiograms. The average practitioner will find it worth his while in improving his knowledge of the physiology of electrocardiography which is covered in simple basic terms in this book. The many illustrations help the reader to understand the text.

The complex and comparatively new concepts of spatial electrocardiography are difficult to comprehend unless the reader follows the author's suggestion that each chapter be read in succession, as the subject matter is arranged in a graduated manner. No attempt should be made to short cut reading in an attempt to understand this text. The various graphs showing normal and abnormal changes are well presented and explained in detail.

H. Q. PANG, M.D.

Modern Treatment—A Guide for General Practice.

Edited by Austin Smith, M.D. and Paul L. Wermer, M.D., 1146 pp., Price $20.00, Paul B. Hoeber, Inc., 1953.

As the title of the text implies, this is a fine, up to date, easy to read manual on treatment.

Every known medical problem and disease is covered systematically. Discussions also include concise, up to date methods of diagnosis and physiology, as well as therapy. Especially valuable are the sections on endocrinology and diagnostic techniques, in which the laboratory tools are discussed and results evaluated.

No text covers as much ground in as brief and yet complete a manner as this. It is a one volume encyclopedia on medicine. This is the first edition to be so edited and consists of contributions from fifty-three well known physicians, well qualified on the subjects they contribute. I predict many, many subsequent editions.

Every physician could well utilize such a text in his library.

TORU NISHIGAYA, M.D.

Atlas of Operative Technic—Anus, Rectum and Colon.

By Harry E. Bacon, B.S., M.D., and Stuart T. Ross, M.D., 301 pp., illustrated, Price $13.50, C. V. Mosby Company, 1954.

This atlas is intended to be a source of quick reference for the busy general operating surgeon. Its chief attributes are the quality of its diagrams and above all the excellent job of limiting its contents to generally acceptable tried and proven procedures. The selection of operations upon the anorectal region described in this atlas is excellent and the operative suggestions for surgery of the colon are modern in every respect.

This atlas is an important addition to the general surgeon's bookshelf.

V. C. WAITE, M.D.

Lung Cancer.

By Seymour M. Farber, M. D., 157 pp., illustrated, Price $4.75, Charles C. Thomas, 1954.

On seeing this small book of 136 pages, one wonders how any subject as widely discussed as cancer of the lung can be written into such a small volume and be worthy of reading. What can be said in these few pages of a disease characteristically as inconsistent clinically as pulmonary cancer? The readers will be pleased!

This monograph is one of the finest written on the subject of lung cancer. The discussion is limited to the most important aspects of the disease, ranging from etiology to conclusion in eight chapters. There is no need to weed through a maze of words to learn what is important today. Of course, there is no answer, but the discussion on etiology is interesting. Although in the last fifteen years diagnostic facilities have improved greatly and thoracic surgery has become practical, there has been no appreciable decrease in the time interval between onset of symptoms and hospital admission: thus, the rate of cure has been discouraging. It is natural then that Dr. Farber's chapter on non-surgical treatments attracts attention.

For the research men, the statisticians, perhaps, no. For the busy clinicians interested in lung cancer, it is excellent reading. The general practitioner can save the cost of post-graduate lectures in this fine monograph. It is of interest also that Dr. Farber has quoted the work of Honolulu's Dr. P. W. Gebauer.

WILLIAM S. ITO, M.D.

Acute Renal Failure.

By Arthur Grollman, Ph.D., M.D., 92 pp., illustrated, Price $4.00, Charles C. Thomas, 1954.

This monograph discusses the etiology, pathology, physiology, symptomatology and management of acute renal failure in clear understandable detail in type easily read. Prophylactic measures are emphasized to avert the condition. Management with conservative and, lastly, artificial measures are described. The latter is not emphasized, as it should be, as the majority of our hospitals are not equipped to carry out artificial measures. The majority of patients when properly managed will have no need for the use of artificial measures. This book will be of vital interest not only to a urologist but to all those who will be called upon to treat acute renal failure.

EDMUND ING, M.D.

(*Continued on page 72*)

Blue Shield Plan
for Hawaii®

HMSA—An Integral Part of the Island Economy

J. R. VELTMANN, *General Manager*

As a service organization, HMSA has virtually become a household word in Hawaii and as a result the public does not fully realize that the Association represents a large financial factor in the economy of our community. In its 17 years, HMSA has grown to a mature and well-balanced business, whose functions are similar to that of a financial institution in the Territory —Members pay monthly premiums for medical protection and HMSA disburses funds to doctors and hospitals for services rendered its members.

Let us consider HMSA from a dollar and cents angle for a minute. Do you realize that HMSA will receive about two and one half million dollars in premiums during the year 1954? And that over $2,150,000.00 will be paid to doctors and hospitals for services rendered members representing a return of over 86¢ out of every income dollar paid for medical protection? HMSA is proud to report that for the past 5 years, HMSA has returned to its members nearly 83¢ out of every income dollar through payment of doctors and hospital bills. For the past 3 years, members have received increased benefits without any increase in premiums.

Diligent efforts to streamline internal operations as well as increased membership have resulted in reduced operating costs. It is anticipated that operating costs for 1954 will be nearly 1% less than such costs for 1953. Operating expenses include membership acquisition, payment of medical claims and membership accounting.

As required by Territorial statutes, HMSA allocates approximately 3% of its income to a Contingency Reserve which exceeded $500,000.00 at the end of July 1954. This reserve is maintained to assure available funds to cover services which may result from any major catastrophe or epidemic. These funds are invested along with part of the operating funds of the Association.

The Investment portfolio which now totals $750,000.00 is vested in local financial institutions, utilities, Federal Bonds and Treasury Notes. Income derived from these investments is allocated directly to the Contingency Reserve. It is estimated that in 1954 investment income will bring an average return of 2.4%. The program of investments is guided carefully by the Finance Committee of the Association, which consists of business leaders well versed in finances of the community.

Practically all disbursement of HMSA funds is made locally in order to keep the dollars in the community. Only a small sum is paid out of the Territory in the form of membership fees in the National Blue Shield program. Members who require medical care while away from the Territory of Hawaii are reimbursed for medical services rendered upon their return to Hawaii. Even office supplies and equipment as well as printing services are obtained locally.

HMSA offers employment to 54 Island residents in its Honolulu and branch offices on all major Islands. Turnover in the personnel of HMSA has been relatively slight and many of the employees have been with the Association for many years. Advancement in the organization is always considered from within the ranks which has resulted in excellent personnel relations.

Membership in the Association now exceeds 80,000 representing over 16% of the population. As more citizens become members of the plan and realize the value of medical protection, it is believed that the general health of the community will improve, thereby helping to decrease the number of medical indigents who require public assistance to meet the cost of large medical bills.

The local medical profession, hospitals and HMSA are working in close liaison to develop more comprehensive benefits for the people at rates within the means of the majority of the community to pay for medical protection. Benefits which are demanded by the public and are presently under consideration include diagnostic laboratory and x-ray services, physical examinations, and other services to encourage early detection of an illness which would contribute to a good program of preventive medicine.

One especially popular and interesting benefit requested is coverage for illness from the first home or office call. It is recognized that such a benefit can be very expensive and is subject to abuse, but the plan is making every effort to meet the public demand and offer this service on an experimental basis. At this point it is significant to note that HMSA was the first Blue Shield Plan in the country to offer home and office medical visits as a benefit. Very few Blue Shield Plans or commercial plans offer home and office visits as a benefit to subscribers and dependents equally.

With the development of a sound comprehensive plan, the Territory of Hawaii can be proud of its "own" medical plan, one of the most progressive in the nation. HMSA hopes to continue its progress through a more comprehensive and attractive plan and in so doing, will encourage greater participation of our Island residents, thereby enhancing HMSA's role in the economy of the Territory.

Hawaii Medical Association

Summer Meeting

June 26-29, 1954

Honolulu

Following the Annual Meeting of the American Medical Association in San Francisco, a large group of doctors and wives from the mainland came to Hawaii for a post-convention tour. There were 294 doctors registered for the Summer Meeting of the Hawaii Medical Association, including 239 mainland doctors and their wives. There were approximately 250 doctors present at each of the scientific sessions on June 28 and 29. The fashion show luncheon was attended by 241 ladies. There were 515 persons present at the luau at the Queen's Surf.

The program for the meeting was as follows:

Saturday, June 26 and Sunday, June 27

9:00 a.m.—Registration—Royal Hawaiian Hotel.

Monday, June 28

Scientific Session, Mabel L. Smyth Memorial Building.

1. *Welcome Address* by Nils P. Larsen, M.D., President, Hawaii Medical Association
2. *Panel Discussion on Ulcerating Lesions of the Stomach and Duodenum.*

   Moderator: Nils P. Larsen, M. D.

   Participants:

   Leo L. Hardt, M.D., Clinical Professor of Medicine, Loyola University, Chicago

   Everett P. Coleman, M.D., Chief Surgeon, The Coleman Clinic, Canton, Illinois

   Morton E. Berk, M.D., Internist, Medical Group, Honolulu

   Joseph E. Strode, M.D., Surgeon, Straub Clinic, Honolulu

Fashion Show Luncheon for the Ladies, given by the Woman's Auxiliary to the Hawaii Medical Association, at the Halekulani Hotel.

Buffet Lunch at 12.

Hawaiiana Fashion Show at 12:30.

Commentary by Mrs. Elaine North of United Air Lines.

Fashions by Watumull's.

Tuesday, June 29

Scientific Session, Royal Hawaiian Hotel Ballroom.

Chairman: C. M. Burgess, M.D., President, Honolulu County Medical Society.

Exhibit by Cleveland J. White, M.D., Professor of Dermatology, Loyola University, Chicago
Diseases of Nails

1. *Medicine in Early Hawaii,* Nils P. Larsen, M.D., Internist, Medical Group, Honolulu
2. *Pictorial Review of Leprosy,* Edwin K. Chung-Hoon, M.D., Chief of Medical Service, Division of Hansen's Disease, Department of Health, Honolulu
3. Movie—*Ventricular Excision for Leiomyosarcoma,* Paul W. Gebauer, M.D., Chest Surgeon, Leahi Hospital, Honolulu

Evening at Queen's Surf

Cocktail Hour, Luau (Hawaiian feast with Hawaiian, Tahitian and Samoan entertainment), and dancing till midnight.

Included among those attending the meeting were the Secretary and General Manager of the American Medical Association, the Director of Press Relations of the American Medical Association, 11 members of the AMA House of Delegates, the Presidents-elect of the Wisconsin and Indiana State Medical Associations, the Presidents of the Chicago and New York County Medical Societies, and a Vice President and 3 Past Presidents of the Woman's Auxiliary to the American Medical Association.

Dr. Walter B. Quisenberry was Chairman of Arrangements for this meeting. The Woman's Auxiliary to the Hawaii Medical Association not only presented the fashion show luncheon for the ladies but also staffed the hospitality desk at the Royal Hawaiian Hotel and cooperated in the arrangements for the meeting.

SAMUEL L. YEE, M.D.
Secretary

Give the HMSA a boost——it's your OWN health plan.

County Society Reports

Hawaii

A dinner meeting of the Hawaii County Medical Society was held at the Naniloa Hotel on July 15, 1954.

Doctors Bergin, M. H. Chang, H. E. Crawford, Hayashi, Jenkin, Kasamoto, Kutsunai, Matayoshi, Mitchel, Miyamoto, Oakley, Okumoto, Orenstein, Paynter, Rothrock, Stemmermann, Tomoguchi, E. Wong, Woo, Yamanoha and Yuen were present.

The group was addressed by Dr. N. P. Larsen, President of the Territorial Medical Association. Dr. Larsen presented a series of photographic slides which presented various interesting diagnostic and treatment problems.

GRANT N. STEMMERMANN, M.D.
Secretary

Honolulu

The regular monthly meeting of the Society was held Friday evening, June 4 in the Mabel Smyth Auditorium. Dr. C. M. Burgess presided and approximately 85 members and guests attended.

A very excellent Pathological Symposium was presented by the Program Committee and the following talks were very well received:

Bacterial Endocarditis—Dr. W. Harold Civin
Modern Concepts about Carcinoma—Dr. I. L. Tilden
An Analysis of the Bufo Pregnancy Test—Dr. Raid Chappell

The membership decided to begin evening meetings at 7:30 rather than 8:00 P.M. and to dispense with the July and August membership meetings.

Dr. Rodney T. West discussed current federal legislation pertaining to the practice of medicine and particularly the Kaiser Plan. It was noted that the Kaiser plan was reviewed by the Hawaii Medical Association's House of Delegates and at that time a vote of confidence in support of the HMSA was passed.

The Society unanimously approved the HMSA as a method of insuring the people's health in the Territory.

The revised By-Laws as presented by the Board of Governors were approved. The only controversial section was that pertaining to the formation of the Medical Practice Committee.

The following resolutions in memory of Drs. Frederick L. Morong and Thomas L. Taylor were adopted:

Whereas, Dr. Frederick L. Morong was a general practitioner in the Territory of Hawaii from 1926 to shortly before his death; and

Whereas, He was a life member of the Honolulu County Medical Society and a retired Major, with an unblemished record, from the Hawaii National Guard; and

Whereas, He performed the various duties of his profession in such a way as to endear him to his patients and colleagues; now therefore be it

RESOLVED, That the members of the Honolulu County Medical Society do hereby express their sincerely felt sense of loss at his death; and be it further

RESOLVED, That a copy of this resolution be transmitted to his son, Frederic L. Morong, Jr., and spread upon the minutes of the Society.

* * *

Whereas, Dr. Thomas L. Taylor practiced medicine in the Territory of Hawaii from 1920 to 1953; and

Whereas, He was a life member of the Honolulu County Medical Society and a member of the American Psychiatric Association; and

Whereas, His arduous and often exhausting efforts on behalf of the unfortunate mentally deficient at Waimano Home and later at the Territorial Hospital, were carried out in a spirit of willingness and self-sacrifice in spite of his own serious chronic illness; now therefore be it

RESOLVED, That the members of the Honolulu County Medical Society do hereby express their sincerely felt sense of loss at his death; and be it further

RESOLVED, That a copy of this resolution be transmitted to his wife, Mrs. Ethel L. Taylor, and spread upon the minutes of this Society.

Following adjournment at 10:00 P.M. refreshments were served on the lanai.

* * *

A special membership meeting was held at the Mabel Smyth Auditorium on July 2, to (1) study the recommendations of the Governor's Advisory Committee concerning H. B. No. 692 and (2) elect four members to the newly formed Medical Practice Committee. Dr. C. M. Burgess presided and approximately 75 regular members attended.

Drs. Robert Katsuki and Robert B. Faus were elected to serve on the Medical Practice Committee for two years, and Drs. Lyle Bachman and David L. Pang for one year.

The report of the Governor's Advisory Committee concerns the free choice of physicians in Workmen's Compensation injuries with some limitations. The Board of Governors had previously approved this report in principle.

The preparation and maintenance of a master list of consulting physicians by the Hawaii Medical Association was extensively debated, particularly as to whether it should be handled on a county or territorial level.

An amendment to delete the paragraphs pertaining to the Master List of Consulting Physicians was defeated, and the Society unanimously voted to approve the committee report on a six months' trial basis, with the stipulation that it be reevaluated at the close of the trial period.

Upon adjournment at 8:15 P.M., Dr. Burgess urged the membership to hear Dr. J. Lafe Ludwig discuss his experiences with panel medicine in California. Following Dr. Ludwig's enlightening talk, refreshments were served on the lanai.

J. M. FELIX, M.D.
Secretary

Kauai

The regular monthly meeting of the Kauai County Medical Society was held at the Wilcox Memorial Hospital, Tuesday evening, July 13, 1954, Dr. Peter Kim presiding. Members present: Kim, Fujii, Ishii, Wallis, Goodhue, Boyden and Cockett. Guests were Dr. Schilling of Samuel Mahelona Memorial Hospital and Dr. Angie Connor of the Bureau of Maternal and Child Health.

Dr. Connor requested that a committee be appointed with whom those working on the Kauai Pregnancy Study could consult. The president appointed the following Advisory Committee: Drs. Wallis, Wade and Fujii.

Members of the Territorial Advisory Committee to the Bureau of Maternal and Child Health were present for their annual meeting on Kauai and Dr. Tom, chairman of the group, took charge for the remainder of the evening. Cases of ectopic pregnancy and eclampsia were fully and freely discussed.

Dr. Marie Faus requested that the Committee reconsider the Means Test schedules for Child Health Conferences. It was her opinion that certain families on Oahu were being unjustly excluded. The question was referred to a subcommittee for consideration.

* * *

The regular monthly meeting of the Kauai County Medical Society was held August 10 at the Wilcox Hospital at 7:30 P.M. Members present were Doctors Kim, Wallis, Ishii, Goodhue, Kuhns, Kuhlman, Boyden, Masunaga and Fujii. Guests were Doctors Schilling and Angie Connor.

Before the regular meeting commenced Mr. M. E. Gemmingen reported on Rehabilitation Kauai Unlimited, a recently organized group of young Kauai business men. Their aim is to set up a workshop and retail center and the securing of a full time vocational councillor to aid in this work. The local doctors were urged to mail in the names of all individuals whom they thought could be helped by such training.

President Kim then brought up the subject of whether or not the local Cytological Laboratory should be continued. It was the opinion of those present that the Laboratory should be continued but that the doctors should use it more than they have been recently.

The program committee was instructed to obtain, every few months, speakers from Honolulu representing various fields in medicine.

A motion was made to change the time of our monthly meeting from the second Tuesday in the month to the first Tuesday. Carried.

Dr. Angie Connor reported on plans for testing Kauai Children for hearing loss. The Society had approved the testing of four-year-olds at our June meeting. In addition, it is now planned to examine all the children in the Catholic schools as well as a large segment of the public schools. The Society's approval was given, both for the examinations and for otologic follow-up clinics.

The problem of the mentally retarded or slow to learn child was discussed. The Society approved a proposal that each doctor mail to Miss Myrna Campbell a list of such children under his care between the ages of three and seven. From these, a group of eight would be selected from various parts of the island to be studied later at a special clinic.

A letter was read from Miss Elizabeth Buzzard in which she stated that a Hawaii Chapter of the National Multiple Sclerosis Society was to be formed and requesting our interest and any support we might find it possible to give.

WEBSTER BOYDEN, M.D.
Secretary

Umi Makahiki I Hala*

SURVEY OF HONOLULU HOSPITALS

Children's Hospital: A study of local requirements indicate that the new building should be expanded to provide 120 beds, with complete modern clinical facilities. It should put this institution in its rightful place as the principal center for study and treatment of diseases of children in this area.

Queen's Hospital: It is recommended that an additional building, with 125 general beds, be erected in the near future. This will bring the total beds in Queen's Hospital to the neighborhood of 500, which is about as large as any hospital in a community of this size should be allowed to grow. Above that, the advantages of unit control and concentration begin to disappear, and the institution tends to become unwieldy.

Residents and interns . . . are compensated for the work they do by the training and instruction that they get. A well-organized system of instruction is an essential. This has been a shortcoming at Queen's, and strong efforts should be made to correct it, as soon as conditions begin to return to normal. It is to be hoped that the new medical director will be a man who is interested and experienced in such educational work.

What numbers and types of beds should be in service to care adequately for the population?

General medical and surgical	1,000
Obstetrical	200
Mental	1,400
Mental observation and treatment	50
Feeble-minded and epileptic	800
Tuberculosis	1,000
Children	150
Acute contagious	70
Chronic-indigent	300
Convalescent-nursing	520

These figures are based on the assumption that this area will have a permanent population of about 260,000, one year after the end of the war, when a considerable degree of stabilization will have occurred.

CAPT. LUCIUS W. JOHNSON, MC, USN

*Ten years ago. From Volume 4, Number 1, September-October, 1944.

Notes and News

Taking the plunge . . .

. . . into surgery

Dr. Charles S. Judd returned to his native Honolulu to joint the surgical department of the Medical Group. Dr. Judd graduated from Yale University Medical School. He served his internship and residency in surgery at Queen's Hospital, Honolulu. He received additional training at Tripler Army Hospital and during the past year at Vanderbilt University, Nashville, Tennessee.

Dr. Richard Y. K. Wong announces the opening of his office for the practice of general surgery at 1365 Nuuanu Avenue. Dr. Wong is a graduate of Northwestern University Medical School. He served his internship and almost two years of surgical residency at Wesley Memorial Hospital in Chicago. He received further training in surgery at Tripler Army Hospital for three months and Queen's Hospital for one year. Dr. Wong served two years with the 64th and 14th Field Hospitals in Korea. He is married and has two children.

. . . into pediatrics

Dr. Richard Etsuo Ando announces the opening of his office for the practice of pediatrics at the Medical Arts Building, at Thomas Square. Dr. Ando is a graduate of McKinley High School and the University of Hawaii. He received his M.D. from the University of Michigan School of Medicine, and interned at Harper Hospital in Detroit. He obtained special training in pediatrics at Harper Hospital and the Children's Hospital, Detroit, and at the Cornell University Medical Center, New York City. Dr. Ando is certified by the American Board of Pediatrics. He is married and has two children.

Dr. Roy Ohtani, recently discharged from the Medical Corps of the United States Army, opened his office for the practice of pediatrics at 915 Keeaumoku Street. Dr. Ohtani is a graduate of University of Hawaii and Tulane University Medical School. He received his pediatrics training at Bellevue Hospital, New York City, the University of Colorado Medical Center, Denver, Colorado, and Kauikeolani Children's Hospital, Honolulu. Dr. Ohtani is certified by the American Board of Pediatrics. He is married and has two children.

. . . into urology

Dr. Joseph H. Iwano announces the opening of his office for the practice of urology at the Medical Arts Building, 1010 South King Street. Dr. Iwano is a graduate of Washington University School of Medicine, St. Louis, Missouri. He interned at the Evangelical Deaconess Hospital in St. Louis. He specialized in genitourinary surgery at the McGuire Veterans Administration Hospital and the Medical College of Virginia Hospitals at Richmond, Virginia. Dr. Iwano is married and has three children.

. . . into OB

Dr. Noboru Ogami announces the opening of his office for the practice of obstetrics and gynecology in association with Dr. Satoru Nishijima at 1221 Victoria Street. Dr. Ogami is a graduate of Boston University School of Medicine. He interned at Queen's Hospital and had a years residency in obstetrics and gynecology at Queen's and Kapiolani Hospitals, Honolulu. Dr. Ogami is married and has one daughter.

. . . into Wahiawa

Dr. Robert P. C. Ho announces the opening of his office for the practice of medicine and surgery at 57-B N. Kamehameha Highway, Wahiawa.

. . . into civilian practice

Dr. Chew Mung Lum announces his return from military service and resumption of his practice of medicine in Room 246 Alexander Young Building.

Dr. I. Sam Tashima announces the reopening of his office at 3884 Waialae Avenue. Previous to his army career, Dr. Tashima had practiced in Honolulu for approximately six years.

. . . into new offices

Dr. Cecil A. Saunders, Jr., announces the opening of his office at 1409 Kalakaua Avenue.

Dr. K. M. Amlin announces the opening of his new office at Dr. Depp's former office 305 Royal Hawaiian Avenue.

. . . into plantation practice

Dr. Charles V. Bergquist was appointed Assistant Medical Director at Waialua Plantation. Dr. Bergquist is a graduate of the University of Southern California and recently completed his internship at The Queen's Hospital.

. . . into matrimony

Wedding bells claimed the Honolulu Surgical Society's most eligible bachelor, **Dr. Lester Yee.** The bride, Miss Winifred Bik-Wun Wong, formerly of Canton, China, Hong Kong, and New York City, majored in Child Welfare and Social work previous to her marriage. Our hearty congratulations to Dr. and Mrs. Yee.

Wedding bells also rang for **Dr. Dorothy Natsui,** Honolulu psychiatrist, on May 14, 1954. Dr. Natsui became Mrs. Fred E. LaFon.

. . . into eye training

Dr. Donald Depp and his family left in August for a 3-year trip to the mainland. Dr. Depp intends to specialize in ophthalmology and has enrolled in the basic science course in this field at the University of Pennsylvania Post-Graduate School of Medicine.

. . . into medical photography

Dr. G. M. Halpern has recently opened a photographic laboratory at 251 Young Hotel Building for medical and biological photography. Those who are familiar with Dr. Halpern's beautiful, accurate, and painstaking work are pleased that the doctor has now made his hobby available to his colleagues in the medical profession.

Honoring . . .

. . . accomplished men

To honor the conspicuous and oustanding achievements of the late **Dr. Robert Perlstein** over the past twenty-five years, the Board of Trustees of Leahi Hospital established a "Dr. Robert N. Perlstein Memorial Fund."

Dr. Homer Izumi became a Fellow of the American College of Chest Physicians at the 20th annual meeting of that organization held in San Francisco in June. **Dr. Hastings Walker** is Regent for Hawaii of the College and **Dr. William F. Leslie** of Hilo serves as Governor. The next annual meeting will be held in Atlantic City June 2-5, 1955.

. . . and an accomplished woman

The editors, the staff of the JOURNAL and the Hawaii Medical Association are justly proud and congratulate **Mrs. John W. Devereux** on her recent appointment as a member of the National Board of the Women's Medical College of Pennsylvania. This university is over a hundred years old and is the only women's medical college in the Western hemisphere.

Travellers . . .

. . . to the mainland

Dr. John H. Peyton returned from a three months' tour of mainland medical centers. Dr. Peyton spent considerable time studying poliomyelitis and respiratory diseases at the Boston Children's Hospital, at the Mt. Sinai and Presbyterian Hospitals, New York City, Vanderbilt University Hospital, Nashville, Tennessee, and others. Earlier this year, Dr. Peyton became a member of the American Academy of Pediatrics.

Other new members of the American Academy of Pediatrics are **Dr. Masato M. Hasegawa** and **Dr. George M. Ewing.**

Presenting papers and exhibits at the recent San Francisco meeting of the American Medical Association were **Drs. L. Q. Pang, Ralph Cloward, Harold Sexton, Joseph Palma,** and **George Ewing.**

Dr. Samuel D. Allison attended the annual meeting of the Pacific Dermatological Society held at Colorado Springs. While on the mainland, Dr. Allison also investigated the so-called Kurtin Corrective Surgical Planing method for the removal of acne scars, traumatic scars, and other skin defects.

Dr. Walter Ozawa returned from an extended mainland medical trip. In Cleveland, as delegate from Hawaii, he attended the meetings of the American Academy of General Practice; in Columbus, Ohio, he attended the annual meeting of the Ohio State Medical Association. In San Francisco, he attended the meeting of the American Medical Association.

. . . to Hawaii

Dr. V. E. M. Osorio, kamaaina physician now practicing in Oakland, was a recent Honolulu visitor.

. . . around the world

Dr. and Mrs. Leslie Vasconcellos returned in July from a trip around the world. In Italy, Dr. Vasconcellos attended the meetings of the International College of Surgeons. In Ireland, he participated in the conclave of the International Congress of Catholic Doctors. Dr. Vasconcellos also visited hospitals at Coimbra, Portugal, Paris, Hong Kong, Istanbul, and Bangkok. At these hospitals, he was especially interested in the surgical and laboratory facilities.

Dr. and Mrs. Steele Stewart recently left for an extended tour which will take them around the world.

New internes and residents . . .

. . . at St. Francis

Dr. Nobutaka Kubota is a graduate of Kyoto University, Japan. Previous to his arrival in the Islands, he was affiliated with the First Surgical Clinic of Kyoto University Hospital.

Dr. Pio Pezzi is a graduate of the University of Rome, Italy, Class of 1953. He had a year of internship at the Surgical Clinic in Rome, Italy and also one year of rotating internship at Mercer Hospital, Trenton, New Jersey.

Dr. Miguel Rivera is a graduate of the University of Autonoma de Guadalajara, Mexico. He served an internship at the University Hospital and the Red Cross Hospital of the same city.

Dr. Ned E. Schultz is a graduate of the University of Guadalajara, Mexico. Following graduation, he worked in Obstetrics-Gynecology at the University of Autonoma de Guadalajara.

Dr. Mario P. Bautista is a graduate of the University of Santo Tomas, Philippines. He did post-graduate work in Obstetrics-Gynecology and was Assistant Resident at the Chicago Lying-In-Hospital, 1952.

Dr. Nelia Fernandez is a graduate of the University of Philippines, Philippine Islands. She served a year's internship at the Philippine General Hospital.

Dr. Kenneth Ching is a graduate of the Stritch School of Medicine, Loyola University, Chicago. He served his internship at Queen's Hospital, Honolulu.

Dr. Patricia Randels is a graduate of the Woman's Medical College of Pennsylvania, Class of 1952. She served a rotating internship at the United States Naval Hospital, Maryland.

. . . at Children's

Dr. William Finley Moore, Jr. graduated from Georgia University School of Medicine. He served a year's rotating internship at Ancker Hospital, St. Paul, Minnesota, and two years' pediatric residency at the University of Oregon Medical School, Portland, Oregon.

Dr. E. Karcher Lindemuth graduated from Jefferson Medical College, Philadelphia. He interned at Pottsville Hospital, Pottsville, Pennsylvania, and St. Joseph's Hospital, Reading, Pennsylvania.

Dr. Kinsuke Nishimura graduated from Osaka Medical College, Japan. He served a rotating internship at the National Hospital of Kyoto, at the 35th United States Army Station Hospital, Kyoto, and at St. Francis Hospital, Honolulu.

Dr. John C. Ridge graduated from St. Louis University School of Medicine. He served 12 months' rotating internship and 12 months' pediatrics residency at Jackson Memorial Hospital, Miami, Florida.

. . . at Queen's

Interns:

Dr. James H. Albright, University of Texas, Galveston, Texas.

Dr. Margaret N. Alexander, University of Colorado, Denver, Colorado.

Dr. John H. Allen, Marquette University, Milwaukee, Wisconsin.

Dr. William G. Davis, University of Colorado, Denver, Colorado.

Dr. Gilbert S. Frank, University of Minnesota, Minneapolis, Minnesota.

Dr. Roy I. Iritani, University of Colorado, Denver, Colorado.

Dr. Leonard P. Jones, Marquette University, Milwaukee, Wisconsin.

Dr. Thomas K. L. Lau, St. Louis University, St. Louis, Missouri.

Dr. John R. Lilly, University of Wisconsin, Madison, Wisconsin.

Dr. Barbara M. Moore, University of North Carolina, Chapel Hill, North Carolina.

Dr. Kaoru Sasaki, Creighton University, Omaha, Nebraska.

Dr. William E. Sill, Jr., Albany Medical College, Albany, New York.

Dr. Richard J. Thurrell, University of Wisconsin, Madison, Wisconsin.

Residents:

Dr. Robert L. Carlberg, University of Nebraska, Omaha, Nebraska.

Dr. Keith E. Nesting, University of Alberta, Edmonton, Alberta, Canada.

Dr. Ella E. Sheehan, Oklahoma Medical College, Oklahoma City, Oklahoma.

Dr. Shirley A. Gunn, University of Toronto, Canada.

Dr. Ransom J. Arthur, Harvard Medical College, Boston, Massachusetts.

Dr. Armando Lambach (has not arrived yet), University of Parana, Curitiba, Brazil, South America.

Dr. Arthur J. Oswald, University of Alberta, Edmonton, Alberta, Canada.

Dr. Ekhard Karl Ursin, University of Innsbruck, Austria.

. . . at Kuakini

Dr. Minoru Tamura is a graduate of Yamaguchi Medical College, Yamaguchi, Japan. He served a year's internship at Tokyo First National Hospital, Tokyo, Japan.

Arriving in September for a residency will be **Dr. Noboru Takeda,** graduate of Juntendo Medical College in Japan. For the past three years, Dr. Takeda was associated with Juntendo Medical College as an intern and assistant.

. . . at Kapiolani

Dr. William E. Sherpick graduated from Columbia University College of Physicians and Surgeons. He served a rotating internship and a medical residency at Lenox Hill Hospital, New York City. He then became resident in obstetrics and gynecology at Hartford Hospital, Hartford, Connecticut, and in surgery at McCook Memorial Hospital.

Dr. Anthony Martyniuk attended the University of Graz and Vienna Medical School in Austria. He was affiliated with the University of Graz Clinic from 1940 to 1942 and with the City Hospital of Graz from 1944 to 1948. He emigrated to Canada in 1948 and spent two years in the Canadian Reserve Army. Following his Army service, he became resident in pathology and surgery at the Regina General Hospital. Prior to coming to Hawaii, he was senior resident in obstetrics and gynecology at the Ottawa General Hospital.

Dr. Jose P. Cabarrocas graduated from the University of Havana Medical School. He served a rotating internship and a residency in obstetrics and gynecology at St. Joseph's Infirmary, Atlanta, Georgia.

Dr. Shigeo Natori graduated from Tokoku University School of Medicine, Sendai, Japan. He had a rotating internship and a residency in obstetrics and gynecology and biochemistry at the University Hospital of Sendai. Prior to his arrival in Hawaii, he served still another rotating internship at the Maryland General Hospital, Baltimore, Maryland.

Island News . . .

. . . from Kauai

Dr. Florence Iwasa came to Wilcox Memorial Hospital as resident, July 1, after a residency in obstetrics and gynecology at Kapiolani Hospital. She is a graduate of the Tokyo Medical School.

Dr. B. Talbot Strongman, former resident, left for Honolulu where she planned to take a long vacation.

Dr. Keith Kuhlman returned to his practice August 1 after completing his tour of duty in the army. He served with distinction in Korea and more recently has been stationed at Tripler Hospital.

Dr. Yamauchi, who relieved Dr. Kuhlman at Koloa, is at present visiting with his family in Hilo.

NEWS

Cardiovascular Course

A course in "Newer Developments in Cardiovascular Diseases" will be given at The Mount Sinai Hospital, New York, October 11 through 15, 1954, under the auspices of the American College of Physicians. As the title implies, the recent advances will be stressed. Dr. Arthur M. Master and Dr. Charles K. Friedberg will direct the course and prominent cardiologists and cardiac surgeons will participate.

Chest Disease Conference

A conference on silicosis and occupational chest diseases jointly sponsored by the McIntyre Research Foundation of Toronto, Canada, and the Saranac Laboratory of Saranac Lake, New York, has been arranged for Monday, Tuesday, and Wednesday, February 7, 8, and 9, 1955, in the Town Hall at Saranac Lake.

All communications concerning the conference should be addressed to Mr. Sturgis, Saranac Laboratory, Saranac Lake, N. Y.

Remember——your Bureau of Medical Economics helps you in two ways——it collects your uncollectable accounts——it aids your patient-doctor relationships.

Dramamine's® Effect in Vertigo

Dramamine has become accepted in the control of a variety of clinical conditions characterized by vertigo and is recognized as a standard for the management of motion sickness.

Vertigo, according to Swartout, is primarily due* to a disturbance of those organs of the body that are responsible for body balance. When the posture of the head is changed, the gelatinous substance in the semi-circular canals begins to flow. This flow initiates neural impulses which are transmitted to the vestibular nuclei. From this point impulses are sent to different parts of the body to cause the symptom complex of vertigo.

Some impulses reach the eye muscles and cause nystagmus; some reach the cerebellum and skeletal muscles and righting of the head results; others activate the emetic center to result in nausea, while still others reach the cerebrum making the person aware of his disturbed equilibrium. *Vertigo may be caused by a disease or abnormal stimuli of any of these tissues involved in the transmission of the vertigo impulse, including the cerebellum and the end organs.*

A possible explanation of Dramamine's action is that it depresses the overstimulated labyrinthine structure of the inner ear. Depression, therefore, takes place at the point at which these impulses, causing vertigo, nausea and similar disturbances, originate. Some investigators have suggested that Dramamine may have an additional sedative effect on the central nervous system.

Repeated clinical studies have established Dramamine as valuable in the control of the symptoms of Ménière's syndrome, the nausea and vomiting of pregnancy, radiation sickness, hypertension vertigo, the vertigo of fenestration procedures, labyrinthitis and vestibular dysfunction associated with antibiotic therapy, as well as in motion sickness.

Any of these conditions in which Dramamine is effective may be classed as "disease or abnormal stimuli"* of the tissues including the end organs (gastrointestinal tract, eyes) and their nerve pathways to the labyrinth.

Dramamine (brand of dimenhydrinate) is supplied in tablets of 50 mg. and liquid (12.5 mg. in each 4 cc.). It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.



The site of Dramamine's action is probably in the labyrinthine structure.

*Swartout, R., III, and Gunther, K.: "Dizziness:" Vertigo and Syncope, GP *8*:35 (Nov.) 1953.

LONG BEFORE HOT FLUSHES APPEAR . . .

Patients presenting such classic menopausal symptoms as hot flushes cause little diagnostic difficulty. However, throughout the period of declining ovarian function which may begin long before hot flushes appear, many women complain of distressing symptoms which though less clearly defined are actually due to estrogen deficiency. For example, insomnia, headache, easy fatigability, and symptoms affecting the bones, joints, and the skin may not be readily identified as due to estrogen deficiency because they may occur years before, or even years after cessation of menstruation.

Investigators[1,2] have found that as the body attempts to adjust itself to declining estrogen production, a number of symptoms may appear which call for the prompt institution of estrogen replacement therapy. These symptoms may be nervous, circulatory, arthralgic, or dermatologic in character because the loss of ovarian hormone "withdraws one of the most important metabolic regulators of the organism"[3] and affects many body functions. If such metabolic imbalance or deficiency is evidenced, the administration of estrogen is clearly indicated.

"PREMARIN" presents the complete equine estrogen-complex as it naturally occurs. "Premarin" not only produces prompt symptomatic relief, but it also imparts a gratifying and distinctive "sense of well-being." It has no odor . . . imparts no odor.

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Estrogenic substances (water-soluble), also known as conjugated estrogens (equine). Available in both tablet and liquid form.

1. Werner, A.: Acta endocrinol. *13*:87, 1953.
2. Malleson, J.: Lancet *2*:158 (July 25) 1953.
3. Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc., 1953, p. 23.

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INTER-ISLAND NURSES' BULLETIN

Official Publication of the Nurses' Association, Territory of Hawaii

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A. N. A. CONVENTION

Delegates attending from NATH:
Mrs. Patience Martelon
Miss Mary Neal

Mrs. Leila Miyamoto attended some of the General Duty Sections and program meetings but did not serve as a delegate.

Mrs. Martelon served as one of the tellers for the ANA voting. The actual keeping and counting of the votes was done by an established firm.

Following are several interesting reports; others will be found in the *American Journal of Nursing*.

Report from Mrs. Patience Martelon

The theme of the 1954 ANA convention, "Calling American Nurses to Action," reflected the growing concern of American nurses over the trends which are developing in the health care available to the people of this country. The emergencies of war and its aftermath have been met, but a new and even more serious emergency has developed which is referred to by the public as "the shortage of nurses."

Demands for nursing service are increasing with a population growth of more than 2.5 million people annually, and with the increases in life expectancy as a result of advances in modern science. The phrase, "**shortage of nurses**," implied that through the magic of numbers, these increasing demands can be met. At present six girls out of every 100 graduating from high school enter the nursing profession. It is the goal of the student nurse recruitment program to interest nine out of every 100 graduating from high school in becoming professional nurses. High educational and health requirements, plus the attractions of other opportunities open to young women today, make it unrealistic to believe that a higher percentage could be expected to enter nursing.

An estimated minimum of 50,000 nurses, in addition to the more than 334,000 registered professional nurses actively employed today, are needed to fill budgeted positions open and waiting to be filled. In some hospitals of the country, no professional nurses are on regular duty. Elsewhere, new hospital buildings cannot be fully utilized because there are not enough nurses to staff them.

In 1949, for the first time, the number of non-professional workers exceeded that of professional nurses employed in American hospitals. By 1953, there were 70,000 fewer professional nurses than non-professionals working in hospitals registered with the American Medical Association.

Members of ANA know that the crux of the present health care problem is the **quality of nursing care** available to the public. High standards of professional practice, such as have already been achieved, must be extended and assured of increasing development in the years to come. The economic status of the nursing profession must progress in keeping with the responsibilities nurses carry in society. Democratic participation in organization activities, where there is "strength in numbers" to achieve the desired ends, must be developed to the point where every nurse has a voice in determining directions and working for results which will have an important influence on her future.

The reports published in the Journal and other nursing magazines depict clearly that in the past two years the American Nurses' Association has made great strides in "section organization, research studies, integration of minority group nurses in the association, economic security, legislation, counseling and placement, and international relations."

The following is a resume of the work accomplished by the House of Delegates. They met Monday afternoon, all day Wednesday, and Friday morning.

The opening meeting was called to order by the President, Mrs. Elizabeth Porter.

Invocation by the Reverend Irvin E. Deer, Executive Secretary, Department of Ministry and Institutions, The Church Federation of Greater Chicago.

Roll call by states; total number of nurses registered 9,445 and 53 representatives from 23 foreign countries.

Presentation of the agenda and rules of parliamentary procedure by Mrs. Harry Thomas, Parliamentarian.

Address by the President. I regret that I cannot give Mrs. Porter's entire address. You no doubt realize how broad is the scope and how vast are the responsibilities of the American Nurses' Association. They are far reaching and varied. Mrs. Porter ended her report with: "What, you may ask, is the **role of the individual nurse** in these broad affairs of our association? She has an exceedingly important role to play. The individual nurse concerned with bedside care makes her first contribution by giving the finest possible care to patients. Because of her very close association with patients, she is in a position to make a unique contribution to the development of healthy, well balanced individuals, and to the building of an environment conducive to health. But she must do more. What she can do to give the general public an idea of nursing as a strong social force stirs the imagination. Further, as she studies the policies of her professional organization, she will form her own opinion about those policies and make them known through her section at its various levels. As small tributaries feeding into the main streams make mighty rivers, so do individual nurses working intelligently and creatively at their appointed tasks give a distinctive character to our great profession."

Reports of Secretary, Treasurer, and Executive Secretary were accepted as submitted without discussion.

Nominations from the floor added Mrs. Linnie Laird, California; Miss Beatrice Horsey, North Dakota as board members. Changed Miss Pearl McIver from Committee on Nominations to board of directors.

Applications of the **Virgin Islands** and **Guam Nurses' Associations** were reviewed and accepted. Both become constituent units of the ANA. The waiver would not grant legal status for the practice of nursing outside the Virgin Islands or Guam.

Amendment to the by-laws was proposed that the personal pronoun, "she," denoting sex, be eliminated. This was done in recognition of the steadily increasing number of male professional nurses. This substantiates the resolution adopted in 1950, recommending that there should be no difference made for male nurses in the basic professional nursing curriculum. It does not change the intent of the by-laws.

The **Mary Mahoney Award** was presented to Miss May Maloney, Executive Director of the West Virginia State Nurses' Association. This award was established in 1936 by the "National Association of Colored Graduate Nurses," to give recognition to a member of N.A.C.G.N. dissolved in 1951 and ANA is perpetuating the award which will be presented at each biennial meeting. The award, honoring the nation's first negro nurse, is presented to a person who, in addition to contributing to nursing generally, has made significant contribution to the integration of nurses of racial minority groups in nursing.

The house opposed "**Equal Rights Amendment.**" The ANA Board had expressed opposition in January, but left final decision to the House of Delegates. Miss Janet Geister, Board Member, headed a committee studying this amendment and urged that the decision of the board be upheld. Miss Geister stated that the amendment at first sight was tempting. It looked like a short-cut to secure for women all the rights they have been achieving step by step through action in state legislatures. A more critical look, however, brought to many an awareness of the great perils involved in attempting to achieve these rights through a constitutional amendment. She felt nurses have a dual interest in the question of the proposed "Equal Rights Amendment." Not only are 98 per cent of the profession made up of women, but nursing exists because of its concern for human welfare. The question of whether "Equal Rights Amendment" would wipe out health and safety laws for the protection of women is of paramount importance. The incorporation of such a stand in the ANA legislative program means that all members of the association may be called upon to lend active support by acquainting

congressmen with the stand of the nursing profession.

Constitutions and by-laws, amendments as submitted by the committee and printed in the March American Journal of Nursing, were accepted with minor changes. High point of discussion: conflicting constitution and by-laws of a state nurses' association with ANA constitution and by-laws. Some states' by-laws provide for sections not provided for in the ANA by-laws. A report was requested from representatives of those states which had sections that were not comparable to the national sections. Especially in question was whether these sections were on an occupational or clinical specialty basis. It was then brought to light that the "occupational" or "clinical group" is not defined, therefore, the structure of the ANA sets nurses apart in classes without identifying them. Mrs. Porter stated that the ANA Board of Directors had been struggling with this question for the past two years. They were aware that all over the country there were clinical groups who wished to meet together to discuss the special problems of their clinical area. The board recognizes that some day in the not too distant future, the public and the profession are going to demand certification of specialist nurses in certain fields. The logical development of such recognition would produce, through years of study, an improvement in standards of nursing practice in a specialty, definition of the functions and qualifications, and development of standards. It was moved and accepted that the ANA Board of Directors appoint an impartial committee to study and determine the precise meaning of the term "occupational groups" and report back to the House of Delegates at the next biennial. States may experiment with clinical specialty groups if they so desire, but no organizational structure should be so rigid that it cannot accommodate all its members.

The joint program meeting on "**Professional Functions and Nursing Practices**" was acceptionally good.

Elizabeth L. Kemble, chairman and moderator, stated that nurses are turning to research as one tool in the solution of the present nursing shortage. The purpose of the four year old ANA study on nursing functions is to attempt to bring the current nurse supply more nearly to a level with the increased public demand for nursing care, by making more effective use of nurses' time. One of the facts unearthed by the association's research is that the average general duty nurse spends from 37.9 per cent to 55.5 per cent of her time in direct nursing care. The rest of her time is spent in "keeping records, making reports and requisitions, housekeeping duties, acting as a messenger, and other similar duties." Another finding, common to all states making the study, was an overlapping of duties between levels of personnel within hospitals, with duties so vaguely defined that problems of service for patients were created.

Dr. Everett C. Hughes, Chairman of the Department of Sociology of the University of Chicago, and Consultant to the Technical Committee, outlined the **role of the professional nurse on the health team.** He stated there is an immense amount of medical technology to be performed with meticulous care and skill. It is fully clear that physicians will continue to delegate a great deal of it to someone else, and it is equally clear that the nurse is the person to whom it will be delegated.

Mr. Milton J. Lesnik, Attorney from New Jersey, spoke on the **legal control over nursing functions,** pointing out that the controls over a profession by an administrative agency are based upon the assumption that the professions' functions and activities are defined. He stated that nowhere is this assumption less justified in the control of any profession than that of nursing. Confusion is multiplied, not only by inadequate definitions in the laws themselves and by lay conceptions, but also by opinions among nurses themselves. The destiny of a profession is not preordained, it is self-determined. The basic right of a profession is security and identity. There is evidence that the challenge of identification long dormant is now being met by research and legislative programs, and nursing functions will be defined. He stated that the functions of professional nurses now supported by authority of law fall into seven categories: (1) supervision, (2) observation of symptoms, (3) charting and recording case history, (4) supervision and direction of all auxiliary health workers, (5) execution of nursing procedures and techniques, (6) direction of preventive health care through educational and social agencies, (7) execution of nursing procedures requiring the supervision of a licensed physician; as administering anesthesia, intravenous injections, transfusions and similar acts.

Dr. Howard A. Rusk, Director, Institute of Physical Medicine and Rehabilitation, Bellevue Medical Center, spoke on the "**The Nurse's Role in Rehabilitation**."

Dr. Rusk stated that the first phase is preventive care; the second, definitive medical and surgical care. He stressed the magnificent recuperative and compensatory powers of the patient who is given the type of care he needs in recovering from an illness or adjusting to a disability. The nurse's role in giving this care is primarily that of a

teacher, interpreting to the patients and staff, problems of the aged, chronically ill and the disabled. With preventive medicine, we have added years to life and it is our responsibility to add life to years.

Mrs. Myrtle Coe, Assistant Professor at the University of Minnesota School of Nursing, discussed the rehabilitation of the cardiac patient, stressing the nurse's relationship to the patient, physician and other workers in the field. She also emphasized the prevention of deterioration of a bedfast patient, the psychological aspects of rehabilitation, and vocational rehabilitation.

Mrs. Alice B. Morrissey, Instructor and Supervisor of Rehabilitation Nursing, Bellevue Medical Center, stressed the need to develop leaders who can bring knowledge and skills to the rehabilitation field. She illustrated the nurse's role in a discussion of the rehabilitation of the hemiplegic patient.

Miss Evelyn Gilbertson, Consultant in Mental Health from Philadelphia, discussed the mental health aspects of rehabilitation with emphasis on the need for the nurse to understand basic conflicts of the long term patient, "the key to success in rehabilitation is cooperation."

Institutional Nursing Service Administrators Section meetings.

Miss Evelyn Hamil, Chairman.

Membership has increased by approximately 1,000 in the past year. About 1,300 members were present. There were two general business meetings. At this time reports were read by the chairmen of various committees. The Committee on Functions, Standards, and Qualifications had a busy year. Functions for directors and supervisors were submitted. These were based on the opinions of 400 nursing service personnel throughout the country and I.N.S.A. sections. This report was accepted by the I.N.S.A. section and the House of Delegates without discussion. The committee will continue its work and submit at the next biennial "Standards and Qualifications." They voted at the first business meeting to have the section meetings open to all nurses.

This report does not begin to cover all that transpired during the week, but I sincerely hope I have created sufficient interest so that everyone will study the reports in their nursing journals.

May I express my appreciation to all for making it possible for me to attend this biennial. It was the most outstanding convention I have ever attended and it is with humility that I am proud to be a member of the nursing profession and the American Nurses' Association.

Report from Mrs. Leila Miyamoto

Nurses! Nurses! Who would think there were so many nurses, streaming down the avenue to the coliseum or "convention hall." The sidewalk for two or three blocks was packed with nurses. In the evening this street was patrolled by Chicago's policemen for the protection of the nurses. For business meetings there were two policemen at the coliseum door checking our badges. If we did not have a badge indicating membership of one of the sections, we were not admitted.

The coliseum was ten blocks from the hotels; after the general meeting, we would go back ten blocks plus four more blocks to the Palmer House where the General Duty Section would meet. Up four floors to a very large hall where we would find approximately 500 general duty nurses in session.

We were told that the program of the convention had been formulated by all section chairmen working together as they found they had many common problems.

The outline of "Functions of the General Duty Nurse" was presented and accepted by the section. This outline may be found in a future *American Journal of Nursing*.

We were reminded by Mrs. Mina Kinsworthy that general duty nurses are capable of running their section. They are the grass roots of the association, and their participation in section activities is badly needed for formulating the definition of their standards and qualifications.

I find that, in comparison with the nation, Hawaii General Duty Section is not out in front, but neither is it trailing at the tail. It simply needs more interest and more activity.

The long range objectives of the American Nurses' Association General Duty Section are:

1. Stimulation and promotion of membership in this section
2. Participation of members in section activities
3. Development of a model form of employment standards for the members of the ANA General Duty Nurses Section
4. Improvement of interpersonal relationships and communication between nurses
5. Strengthening public relations within the profession and in the community
6. Active support and promotion of the ANA economic security program
7. Encourage nurses in the section to compile their credentials in permanent record form with PC&PS
8. Active support of the ANA legislative program relating to the practice of nursing
9. Defining functions, standards and qualifications for practice of general duty nurses and head nurses
10. Encouraging nurses to fulfill their community obligations as citizens
11. Support all ANA programs
12. Co-operation with other ANA sections

A stimulating skit produced by the Minnesota State Nurses' General Duty Section, "We-go-pher Functions," emphasized:

The general duty nurse is aware of nursing needs of the patient.

The general duty nurse needs to participate in administration of nursing service.

The general duty nurse is capable and willing to fulfill community obligations as a nurse.

We are asking Minnesota for permission to reproduce this skit for our general duty section at our Territorial Nurses' convention.

The general duty nurses in connection with the Institutional Nursing Service Administrators Section are now concerned with defining the functions of the head nurse, and a survey is now in progress.

Now that the functions of the general duty nurse have been accepted, the National General Duty Section is concerned about formulating standards and qualifications of the general duty nurse. Specific items of qualifications mentioned were:

The general duty nurse must become more skillful as team leader, able to make the most of her subsidiary workers, and still keep standards of bedside nursing high.

Report from Miss Mary Neal

During its first two years of life, the Educational Administrators, Consultants and Teachers Section has developed forty-one state sections with a total of 7,412 members including associate members. Membership interest in the youngest ANA section is active as was indicated at the recent Chicago convention. 1,539 members of EATC, or one out of every 5.5 of the section's total membership, attended the convention.

The North Ball Room of the Conrad Hilton, with a seating capacity of 300, was provided for EATC meetings. Members flooded the room, some 1,000 strong! Every inch of space, including aisle and stage, was filled to overflowing at the opening business session. Needless to say the room was warm! However, the physical handicap did not detract from delegate participation. Delegates attended the convention to do business, and in spite of heat and crowded quarters, the business at hand was accomplished. From the onset of the meetings, floor delegates were busy with well thought out, planned discussion topics which were brought before the officers. Floor participation was also very active at the sessions of the House of Delegates.

One of the highlights of the first EATC section meeting was a sociodrama entitled "Getting It Straight." The skit, sprinkled with humor, brought out the differences between the functions of ANA's EATC Section (which deals with problems regarding the responsibilities of the individual practitioner) and the NLN (which is concerned with organizing nursing services and education).

After two days of "hot" sessions in the Hilton North Ball Room, EATC meetings were conducted at the Coliseum.

Flowers from Hawaii arrived in excellent condition and scored another convention highlight. ANA officers and delegates were delighted with their orchid leis from the Honolulu Chamber of Commerce and the Oahu District Nurses' Association. For many this was their first experience with the Hawaii aloha garland. Orchid corsages sent by the Maui Association were lovely. Ella Best was delighted with her orchid corsage, as were the others. Everywhere you looked in convention halls, you could spot colorful leis and orchids from Hawaii. The sight was delightful.

I thank you for the privilege of being EATC convention delegate from NATH. The experience was enjoyable as well as constructive.

PUBLIC RELATIONS WORKSHOP

How to provide for proper communications was the keynote of the Public Relations Workshop, which was held under the auspices of the American Nurses' Association at the Moraine-on-the-Lake, Highland Park, Illinois, on June 28, 29, and 30. The workshop, which was attended by 42 state and three territorial participants, was held concurrently with the Legislative Conference to serve as a practice field in public relations.

The three day session was devoted to planning of an effective SNA public relations program, the techniques of public relations in molding public opinion and guidance in adapting the information gained in connection with legislation to other SNA activities. In addition, experience in the mechanics of disseminating information was included. Each participant was assigned to cover a part of the Legislative Conference as a reporter.

David U. Snyder, Public Relations Counsel for the ANA, listed pitfalls in public relations programs. He cautioned workshop participants to "look well before leaping into a barrel of printer's ink." He emphasized the need for careful definition and clarification of the situation; the aims of the program; public relations' role in relationship to the activity; the "target" to be aimed; the methods for best reaching these "targets"; timing; the use of co-operating groups and the means for forestalling opposing factions, and how much in terms of time, money, and manpower the program is likely to require.

Mr. Snyder defined public relations as the measure of attitude or opinion towards a group

and declared that the first step in planning a public relations program should be a calm and deliberate diagnosis of the problem. He stressed the importance of detailed investigation of the problem before the final approach can be attempted.

An ANA public relations worksheet was presented to illustrate the methods of planning used on the *national level.* This blueprint listed the topics for discussion at staff conferences and included (1) major activities, (2) primary aims, (3) public relations' role, (4) "target" or audience, (5) timing, (6) co-operating groups, (7) public relations methods, and (8) the budget. The ANA public relations counsel said that state programs may be designed along these lines with allowance for flexibility.

"It is impossible to do all the program," he said. "Select those which can be done and done well, and defer the others until a more appropriate time."

The participants were divided into three groups to discuss areas which are pertinent in setting up an effective, far-reaching public relations program. The major topics which were considered were the external media, internal media, and marshalling leadership opinion in the community and other organizations. The discussion group reports were in brief:

1. An informed membership with a unity of purpose is essential.
2. In marshalling leadership opinion in the community and from organizations, seek such support which these groups are able to offer and concentrate on the middle group of persons in the organizations who do not have fixed opinions. Convince those who are open-minded and later the opposing faction.
3. Scout for "hidden talents" for writing and speaking among the members of the Nurses' Association and utilize these individuals to act as district reporters and members on the public relations committee.
4. Ask the assistance of local editors, journalism instructors, public relations people, radio and television staff for pointers on the establishment and maintenance of an effective publicity program.

HIGHLIGHTS OF BOARD OF DIRECTORS MEETING

June 18, 1954

Action—That Finance Committee meet with officials of Bishop Trust Company regarding notice of increase in cost of handling business to $60 per month as of July 1954. (Ed.—Committee was able to have it decreased to $50 per month.)

Action—Sent letter to Hawaii League for Nursing requesting a statement regarding need for continuation of Territorial scholarship.

Action—Approved request from Commission on Nursing Education and Nursing Service to write to ANA for funds to continue nursing function studies started in Hawaii. A pilot study has been completed at Leahi Hospital.

Heard report on Nursing Service Bureau. This has been taken over by the Board of the Mabel Smyth Building. If this Board should ever desire to see the Bureau, the District has first privileges for buying it.

Action—Approved purchase of new file cabinet for NATH office.

Committee reports to Board:

Personnel Committee, Mrs. Esther Stubblefield, Chairman presented revised "Conditions of Employment" for personnel employed by NATH and the Board for the Licensing of Nurses. Accepted by Board.

Finance Committee, Lawrence Katsuyama, Chairman, presented a tentative budget for 1955 totaling $11,766.66. (Ed.—This Committee has met since the Board meeting with the President and two other island representatives, and reduced the proposed budget to $10,316.66.)

Program Commtitee, Mrs. Alice Scott, Chairman, annual meeting in Honolulu, October 13, 14, 15.

Constitution and By-Laws Committee was given permission to revise by-laws to coincide with recent revisions of ANA's by-laws.

Membership Committee, Miss Margaret Nott, Chairman, sent written report. (Membership as of July 646 active, 92 associate.)

Legislation Committee, Mrs. Myrtle Schattenburg, Chairman, discussed a possible legislative program for NATH. Board suggested (1) continued support of University School of Nursing, (2) investigate and support needs of Territorial Hospital, (3) consider continued need for scholarship fund, (4) keep in mind policy of ANA activity only for legislation concerning nurses and/or nursing, (5) revision of nurse practice act.

Nominations Committee, Mrs. Emilia Centeio, Chairman.

Proposed ballot:

President:
SISTER MARY ALBERT
LAWRENCE KATSUYAMA

Second Vice President:
ALISON MacBRIDE
THELMA HENSLEY

Treasurer:
MRS. HELEN WILLIAMS
ELIZABETH MIDDLETON

Board Member, Maui:
MRS. MARJORIE OKINAKA

Board Member-at-large:
MRS. ELIZABETH McCALL
MRS. PATIENCE MARTELON

Economic Security Committee, Mrs. Gladys Leong, Chairman.

Board approved:

1. Economic Security Committee to serve as a coordinating committee in the economic security program.
2. A group be appointed to collect pertinent data needed by all sections as, cost of living index, conditions on mainland, conditions of employment of other local groups; also to review survey questionnaires.
3. That Economic Security Workshop be made available to the other islands upon request and assumption of financial responsibility.
4. That nurses be encouraged to form local units in the hospitals to implement the economic security program.

5. That Economic Security Committee become active in continuing education of nurses in regard to economic security program.

ANA was contacted relative to a field worker to assist in the development of "Minimum Conditions of Employment." ANA's response was that it would be better for local nurses to develop their own. Efforts on the economic security program will be concentrated by the sections on the development of functions, standards, and qualifications, and minimum conditions of employment.

Economic Security program ballot report:

Ballots issued	629
Ballots returned	298
Votes favoring program	292
Votes against program	5
Not indicated	1

INSTITUTIONAL NURSING SERVICE ADMINISTRATORS SECTION

Mrs. Patience Martelon, Director of Nursing at Leahi Hospital, gave a brief summary of the recent American Nurses' Association Biennial to members of the Institutional Nursing Service Administrators Section of the Nurses' Association, Territory of Hawaii, at a meeting held on July 14. Mrs. Martelon was the section's delegate to the convention. She is also chairman of the Functions, Standards, and Qualifications Committee for the Nursing Service Administrators Section and, as such, reported on the progress of her group. Mrs. Margaret Rodearmel, Operating Room Supervisor at Leahi Hospital, chairs a similar committee for supervisors. This committee is working on a questionnaire to be sent out to various supervisors.

Mrs. Elaine Johnson, Administrator at Maunalani Hospital and Convalescent Home, is chairman of two very important committees for the section. One is the Committee on Minimum Conditions of Employment for nursing service administrators and the second is the Program Committee. The section program at the annual NATH convention in October promises to be very interesting. Mrs. Johnson, in collaboration with Miss Mary Marshall, chairman of the Committee on Administration of the Hawaii League for Nursing, is working on a panel discussion on the writing and interpretation of references along with some of the technics found useful in discussing a below average work record with an employee.

Miss Hannah Richards, chairman of the Minimum Conditions of Employment Committee for supervisors, was unable to attend the meeting because of the serious illness of a relative.

MEMBERSHIP STATUS

There has been a question relative to the membership status of nurses employed full time in other positions. The following is from ANA in answer to a request for clarification:

We are glad to clarify the meaning of Article III, Section 3, of ANA bylaws: Associate membership is designed for those retired or inactive nurses whose incomes are thus curtailed, but whose interest and enthusiasm is undiminished as valuable participating members in their professional organizations. Nurses employed in any type of position benefit from the programs of their professional organizations and as actively employed people can reflect their needs and wishes through active membership. Thus, nurses employed as physio-therapists, health educators, or any other type of employment for more than thirty days of the calendar year are ineligible for associate membership.

Tentative Program of 23rd Annual Meeting of Nurses' Association, Territory of Hawaii, Inc.

Dates: October 13, 14, 15, 1954 at Mabel Smyth Building.

Wednesday, October 13—Hostesses, Hawaii District
- 8-9 a.m.—Registration
- 9-12—Business meeting
- 1:30-4:30 p.m.—Section meetings

Thursday, October 14—Hostesses, Maui District
- 8-9 a.m.—Film showing (Polio nursing)
- 9-12—Newer aspects of medical and nursing care of polio
- 12 noon—Poi luncheon, Queen's Alumnae
- 1:30-4:30 p.m.—Section meetings
- 6:30 p.m.—Banquet, Hostesses, Oahu District

Friday, October 15—Hostesses, Kauai District
- 9-12—Business meeting (House of Delegates)
- 1:30-4 p.m.—Program by Hawaii League for Nursing

S. F. Q. ???*

The new structure has allotted to the nurses associations the study and determination of STANDARDS, FUNCTIONS and QUALIFICATIONS. These are words that present two difficulties:

I. They hold no meaning for some of us.

II. They hold different meanings for others of us.

Undoubtedly, we shall be seeing definitions and descriptions of standards, functions and qualifications appearing more and more in nursing literature. It may be well, however, to begin thinking of them for ourselves.

We might take the word STANDARD. What does it mean? A simple exploration of the dictionary gives us the following pertinent definitions:

I. That which is set up or established by authority as a rule for the measure of quantity, weight, extent, value, or quality, OR

II. That which is established by authority, custom or general consent, as a model or example; criterion; test. (Webster's Collegiate Dictionary, 5th Edition)

In other words, if we study standards we are being asked to study and set up criteria of quantity; extent and quality of nursing. This is no simple thing to do and yet each section of the Indiana State Nurses Association has a commission, from all of us, to do it. It touches all of nursing; and, if we do it well, may be the means both of better care for patients and deeper satisfaction and happiness in our work for ourselves.

What type of thing exists for which we might develop standards in nursing?

I. We need to know EXACTLY what a patient needs in the way of nursing care.
- A. From the hospital
- B. From the public health agency
- C. From the office nurse
- D. From industry

*Reprinted from *The Indiana Nurse*, December 1953.

E. From the school system
F. From private contractors.

This may sound vague but actually are we not doing things today that are no longer necessary? outmoded by present practice? Are we not aware of areas of patient need that are untouched?

II. We need to know EXACTLY what nurses ARE doing in every special field.

III. We need to put these two lists, these two studies, together, note discrepancies and formulate:

A. A standard of nursing service for patients.
B. A standard of nursing education for both basic and advanced students.

IV. We need to evaluate what we do in terms of need for preparation, type of responsibility, time and effort expended and set a just and realistic standard of compensation and personnel policy for each type of nurse in each type of employing agency in varied communities.

V. We need to study positions and set up standard titles, job qualifications and standards of expected preparation for jobs.

VI. We need to study the non-professional nurse and her contribution to patient care. To give good patient care, how many professional nurses do we need? How many non-professional nurses can we use safely?

We need a standard in terms of ratio for varied situations.

VII. We need to study facilities and equipment. Are there minimums the lack of which produces poor nursing care? Or hamper the development of nursing itself?

VIII. We need to study the organizations within which we work. Do their structures offer us consultation with other groups or do we work in a walled up nursing service? Should one of our standards be the OPPORTUNITY for cooperative effort to produce excellent patient care?

Pages more could be written on areas which we might touch as we study standards. One of the most obvious things in looking at standards is that we cannot do a realistic job alone; nor can we do a realistic job away from the practical situation. If sound standards are to be set up, each section must plan and lead its members in making the approach WHEREVER THEY ARE WORKING. It calls for a united effort; it calls for 100% participation. It also requires the help of many other people who are not nurses; the recipient of nursing care, the doctor, the administrator, personnel men, school authorities, and many others.

It is a big job, a vital job: our challenge—to do it!

HELEN WEBBER, *President*
Indiana State Nurses' Association

NURSES' ASSOCIATION, COUNTY OF HAWAII

The Nurses' Association, County of Hawaii, welcomed their new officers for two year terms on June 14, 1954. They are as follows:

President:
MRS. EDNA BALDWIN
Second Vice President:
MRS. HATSUMI ISHIKAWA
Treasurer:
NORIYE TAKEHIRO
Directors:
MOIRA WILSON
MRS. MARTHA NAGAKURA

Outgoing officers:

President:
MRS. ELIZABETH STILLMAN
Second Vice President:
MRS. HAZEL FLAGG
Treasurer:
MARY E. STANLEY
Directors:
MRS. CHIYO MEYERS
MRS. HATSUMI ISHIKAWA

Miss Mary E. Stanley vacationed on the mainland, visiting the different countries. She accompanied Mrs. Guido Giacometti of Hilo, a very close friend. During her absence, Miss Eunice Graham was our acting treasurer.

Miss Moira Wilson was on the mainland visiting friends for three months.

Miss Miriam Kemmerer, Director of Nurses, Hilo Memorial Hospital, also went to the mainland for vacation and at the same time visited some of the hospitals there.

Mrs. Betty Kuroda, staff nurse, Hilo Memorial Hospital, left for Oklahoma on July 5 to be with her husband.

A food and rummage sale was held for two days in August, and many members participated in making it a success.

To all our new officers, we greet them Aloha; and to all our outgoing officers, mahalo nui loa.

BOARD FOR THE LICENSING OF NURSES

Nurses licensed in the Territory—January 1-June 31, 1954:

Professional nurses by examination	6
Professional nurses by endorsement (reciprocity)	113
Practical nurses by examination	60
Practical nurses by endorsement	8

SCHOLARSHIPS

There are still funds available from the Territorial scholarship for local born nurses for advanced nursing education who will return to the Territory for work in supervision, teaching, or administration in nursing.

If interested, write the Board for the Licensing of Nurses, 510 South Beretania Street, Honolulu, or call 54328.

COUNSELING AND PLACEMENT

Positions for nurses in the Territory are difficult to list as our material must be presented two months before the Journal reaches you; but when you are changing jobs, you might like to investigate what we have available.

We have listings of positions available in foreign countries and in our own country, U. S. Civil Service Commission jobs (which include the Indian services), and some jobs in specialized services in state and private hospitals.

Through this office one nurse went to Wake Island, another to the Trust Territory; several have been put in touch with positions on the mainland.

If we don't have what you want, perhaps we can find someone who does.

HAWAII CHAPTER NATIONAL MULTIPLE SCLEROSIS SOCIETY

Recent newspaper publicity has disclosed a group of territorial residents with multiple sclerosis and related neurological diseases. This group, along with other interested persons, plans to organize a Hawaii Chapter of the National Multiple Sclerosis Society.

This chapter would have two primary purposes:

1. To acquaint present and future victims with the National Society and its efforts on their behalf.
2. To acquaint victims with others similarly afflicted.

A chapter would also:

1. Make available information about MS to all those interested.
2. Make community facilities available to sufferers.
3. Provide chapter contact and directions to prompt aid, if necessary, to mainland visitors with MS.

Persons interested should contact Miss Elizabeth Buzzard at Maunalani Hospital and Convalescent Home, 5113 Maunalani Circle, telephone 71981, between 10 a.m. and 2 p.m., or write to the above person.

PLANS FOR ASSEMBLING INFORMATION PERTINENT TO NURSING HISTORY

Nursing, though comparatively young as a profession, is rich in the events—and in the personalities who shaped its course—that brought it so swiftly into great usefulness. It has risen to take its place among the major professions devoted to the welfare of man. It is on the threshold of a usefulness so broad that we can only guess at its potentialities.

It is most important, therefore, that we engage ourselves seriously in the business of assembling, identifying, and organizing the written record of the past. Unquestionably some of the valuable material relating to the profession's early history has been irretrievably lost. But unquestionably too, a great deal of it is still available, not only in the files of nursing schools and professional associations but in the personal possessions of many of our pioneers, or their heritors.

The National League for Nursing and the American Nurses' Association have embarked on a plan centered around the orderly identification and mobilization of our early source material. *The plan at present, does not call for the collection of such material at any central point.* Rather, the primary effort is to locate, describe and list letters, diaries, documents, photographs, and similar materials that bear on the early history of nursing. The plan is to learn what historical data are available and where. *After* that will be considered what should be done to make these collections more accessible and useful for the purpose of general study, reference and research.

If you have material pertinent to the history of nursing, national or territorial, please inform the NATH office. If you have such materials you do not wish to keep, please sent it to NATH office for filing. This information will be kept until such time as the national committees formulate plans for its use.

BOOK REVIEWS

(*Continued from page 53*)

The Technique of Psychotherapy.

By Lewis R. Wolberg, M.D., 869 pp., Price $14.75, Grune & Stratton, Inc., 1954.

This volume presents in a clear and orderly manner all the essentials of psychotherapeutic technique. Dr. Wolberg presents a comprehensive review of the prevalent schools of psychotherapy (excellent for preparation for Board exams). Then he correlates all the positive factors of the various systems of psychotherapy into a "basically sound therapeutic structure." The result is a flexible framework for psychotherapy which is described phase by phase from first to final interview.

All who are concerned with the practice of psychotherapy, regardless of orientation, will find this an extremely valuable book. It is a massive volume of over 800 pages, but the reader will be amply rewarded. The more experienced practitioner will find suggestions to expand his therapeutic skills while the beginner will find an excellent step-by-step working manual.

PERSHING S. LO, M.D.

The Hypertensive Disorders of Pregnancy.

By Ernest W. Page, M.D., 120 pp., Price $3.75, Charles C. Thomas, 1953.

This is a well written, concise summary of the present knowledge of this subject. The book is divided into four parts. The introduction is a review of the history of hypertension during pregnancy, and definition of terms. The second part of the book deals with the clinical aspects and the interpretation of clinical findings. The third section discusses the physiological and biochemical changes during normal pregnancy and during toxemia. Here the author interjects a good deal of his own work on this subject and correlates it with most of the well known work in this field of physiology. The last section deals with the etiology of toxemia. The author does not state the "cause" but discusses the various hypotheses and the newest concepts and treatments.

Anyone interested in the toxemias of pregnancy should read this excellent review of the subject.

SYLVIA HAVEN, M.D.

The Diagnosis and Treatment of the Infertile Female.

By Fred A. Simmons, M.D., 83 pp., Price $2.50, Charles C. Thomas, 1954.

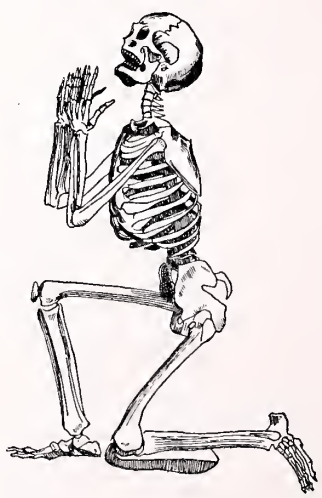
Although labeled a monograph, this short exposition reads more like a series of lectures, expanded and recorded, on a difficult clinical problem. Under standard headings, the usual aspects of diagnosis and treatment are considered. The discussion, however, is frequently so over-simplified that the significance of many essential elements is obscured. Sections on the technique of tubal insufflation and hysterosalpingography, and a long quotation from a geneticist regarding the effects of irradiation on mammalian germ plasm, are included. A bibliography, a physical examination form for sterility-case work-ups, and an index complete its architecture.

For the student or practitioner making his first ac-

9 Doctors & God

By FRANCIS JOHN HALFORD, M.D.

A doctor's lively account of the hardships and triumphs of nine New Englanders who ventured to the Hawaiian Islands as medical missionaries, the first arriving on the brig *Thaddeus* in 1820 with the earliest band of American missionaries. How they practiced their profession under the most primitive conditions, without antiseptics or anesthetics, is vividly told through use of unpublished private journals and personal letters. *Price: $4*



available October 7
at your bookstore or

University of Hawaii Press
Honolulu 14, Hawaii, U.S.A.

quaintance with the subject of infertility in women, it contains some useful information. To the trained gynecologist, it is simply a restatement of fundamentals, with several insertions that are clearly just one man's opinion.

The author has unfailing enthusiasm for the somewhat unreliable basal body temperature method of determining ovulation. He completely ignores the several useful absorbable opaque media for salpingography; and, like too many other medical writers, he has not learned that the words "media" and "data" are plural, not singular.

The book is recommended as a library reference work for the uninitiated.

LYLE BACHMAN, M.D.

Also Received

Why We Became Doctors.
Edited by Noah D. Fabricant, M.D., 182 pp., Price $3.75, Grune & Stratton, Inc., 1954.

Fifty noted physicians' explanations of why they got that way, including such unexpected ones as Havelock Ellis.

Progress and Problems in Mental Hospitals.
Edited by Daniel Blain, M. D., 204 pp., Price $2.50, American Psychiatric Association, 1953.

Proceedings of the Fifth Mental Hospital Institute, paper bound, and primarily of interest to mental hospital administrators.

The Physiology of Man.
By L. L. Langley, M.A., Ph.D., and E. Cheraskin, M.D., 609 pp., illustrated, Price $5.50, McGraw-Hill Book Company, Inc., 1954.

A simple and palatable presentation by two Alabama physiologists.

The Hidden Causes of Disease.
By Antonio Benivieni, translated by Charles S. Singer, 215 pp., Price $6.75, Charles C. Thomas, 1954.

A beautifully printed facsimile edition of a 16th century Italian medical classic, smoothly translated. Fascinating!

Atlas of Distribution of Diseases.
Rickettsial Diseases, Tick and Mite Vectors, Price $1.25 folded, $1.50 flat, American Geographical Society, 1954.

Another in the series of excellent and authoritative world maps of great medical reference value.

The Medical Clinics of North America.
New York Number, May, 1954—Differential Diagnosis of Internal Diseases, pp. 637–941, $18 per clinic year cloth binding, $15 per clinic year paper binding, W. B. Saunders Company, 1954.

Nineteen articles emphasizing practical aspects of differential diagnosis in a wide variety of diseases and disease syndromes.

The Surgical Clinics of North America.
June, 1954, Lahey Clinic—Surgery in Poor Risks and Aged, pp. 587–871, figs. 163–222, $18 per clinic year cloth binding, $15 per clinic year paper binding, W. B. Saunders Company, 1954.

Thirty articles on surgery in aged and poor risk patients, embracing the fields of general surgery (11 authors), neurosurgery (5), orthopedic, urologic and otolaryngologic (3 authors each), 2 in anesthesiology, 1 each in radiology, allergy and pathology, and 10 in internal medicine.

The Bacterial Factor in Traumatic Shock.
By Jacob Fine, M.D., 82 pp., Price $2.75, Charles C. Thomas, 1954.

A 71 page analysis of an often forgotten aspect of this important surgical catastrophe.

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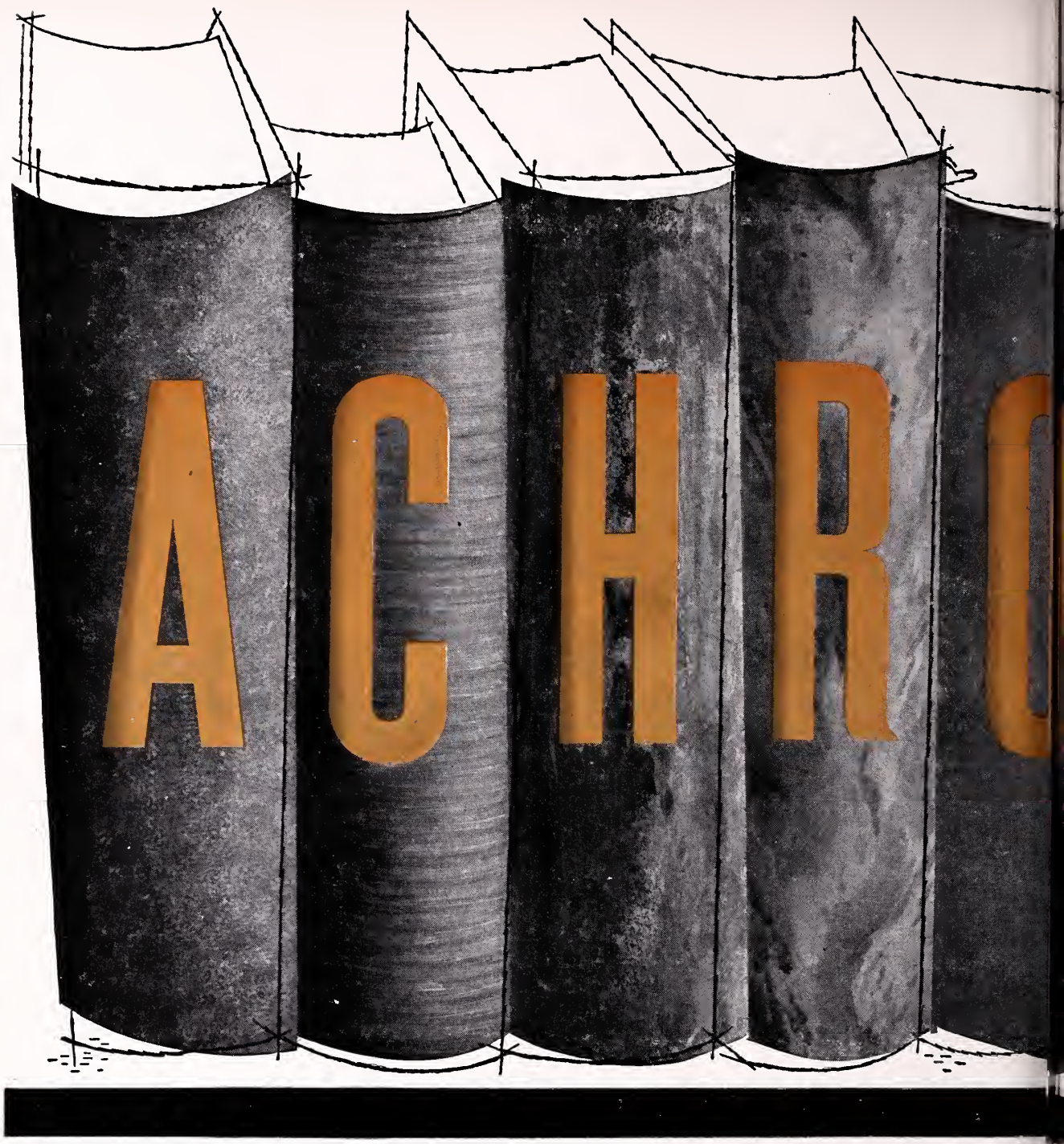
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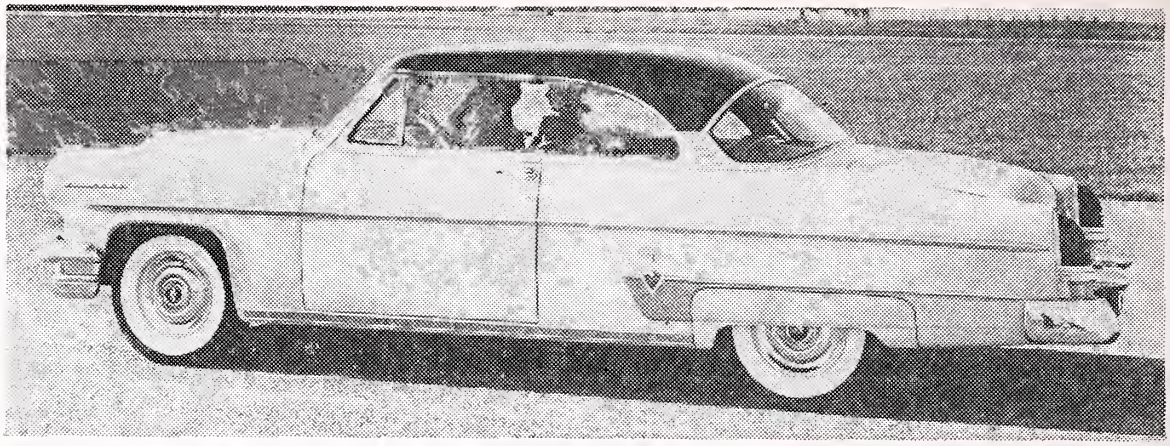
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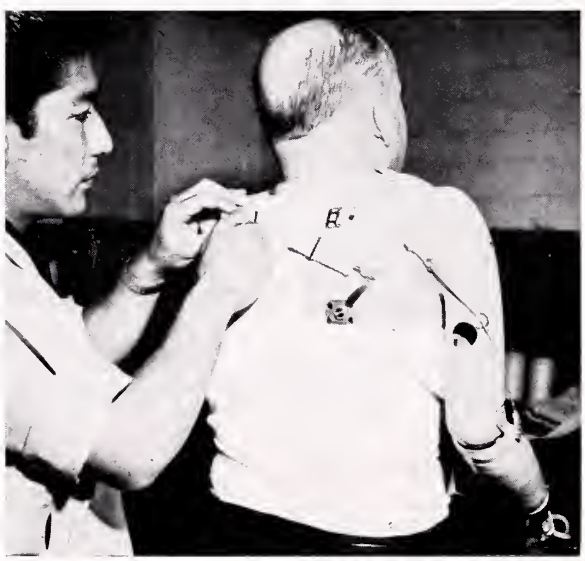
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On dosage of 1 Gm. per day for 120 days, ototoxicity was as follows*:

	Vestibular damage % of patients		
	Mild	*Moderate*	*Total*
Streptomycin	12	6	18
Dihydrostreptomycin	6	0	6
Distrycin	0	0	0

	Cochlear damage % of patients		
	Mild	*Moderate*	*Total*
Streptomycin	0	0	0
Dihydrostreptomycin	12	3	15
Distrycin	0	0	0

**Heck, W.E.; Lynch, W.J., and Graves, H.L.: Acta oto-laryng. 43:416, 1953.*

Distrycin dosage is the same as for streptomycin. In tuberculosis the routine dose is 1 Gm. twice weekly, in conjunction with daily para-aminosalicylic acid or Nydrazid (isoniazid). In the more serious forms of tuberculosis, Distrycin may be given daily, at least until the infection has been brought under control.

SQUIBB

a leader in streptomycin research and manufacture

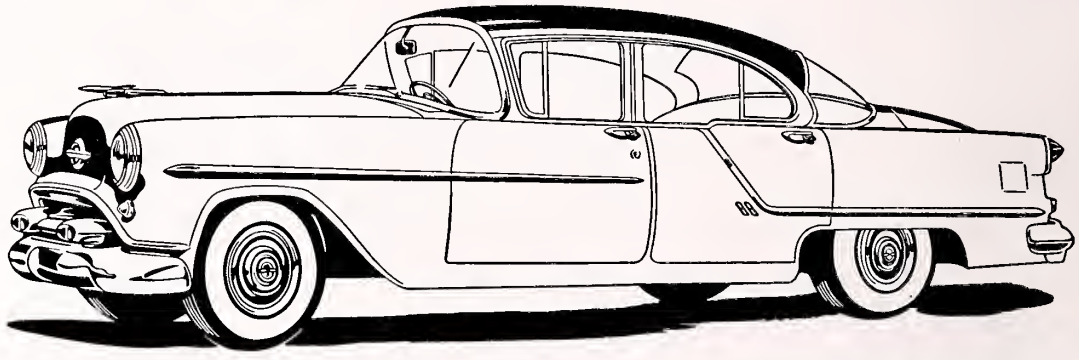
'Distrycin'® and 'Nydrazid'® are Squibb trademarks

Distrycin is supplied in 1 and 5 Gm. vials, expressed as base

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gives you the greatest pick-up speed, performance and economy with ITS BIG

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VASCULAR HEADACHES
Reminder #1

GYNERGEN-INJECTION *test–*
a guide to proper therapy

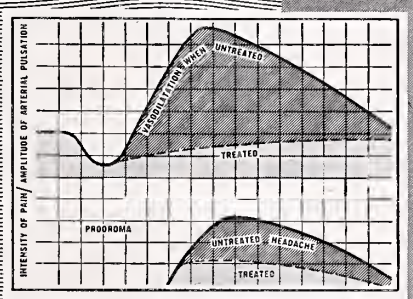
INJECT: 1 cc. (0.5 mg.) i.m. Ergotamine Tartrate (Gynergen N.N.R. 1950).

RELIEF: indicates headache is vascular (e.g., migraine).

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

CAFERGOT
TABLETS

for relief of
subsequent migraine attacks



EFFECT OF CAFERGOT ON COURSE OF ATTACK*

Gynergen® has been shown to be *specific in relieving* the throbbing, recurrent head-pain typical of vascular headaches. The pain is due to dilatation of cranial arteries.

By reducing the amplitude of pulsation, Gynergen interrupts the pain-causing mechanism.

Therefore, when the Gynergen-injection test is positive, Cafergot® tablets (Ergotamine Tartrate 1 mg. and caffeine 100 mg.) is an effective and convenient treatment for subsequent attacks.

DOSAGE: 2 or 3 tablets by mouth at first symptoms (either at prodroma or onset of head pain). Additional tablets as indicated, at ½ hour intervals (6 maximum).

Supplied: Bottles of 20 and 100 tablets.

*(adapted from Wolff, H.G.: Headache and Other Head Pain, Oxford University Press, New York, 1948, p. 268.)

Literature on Vascular Headaches, yours for the asking.

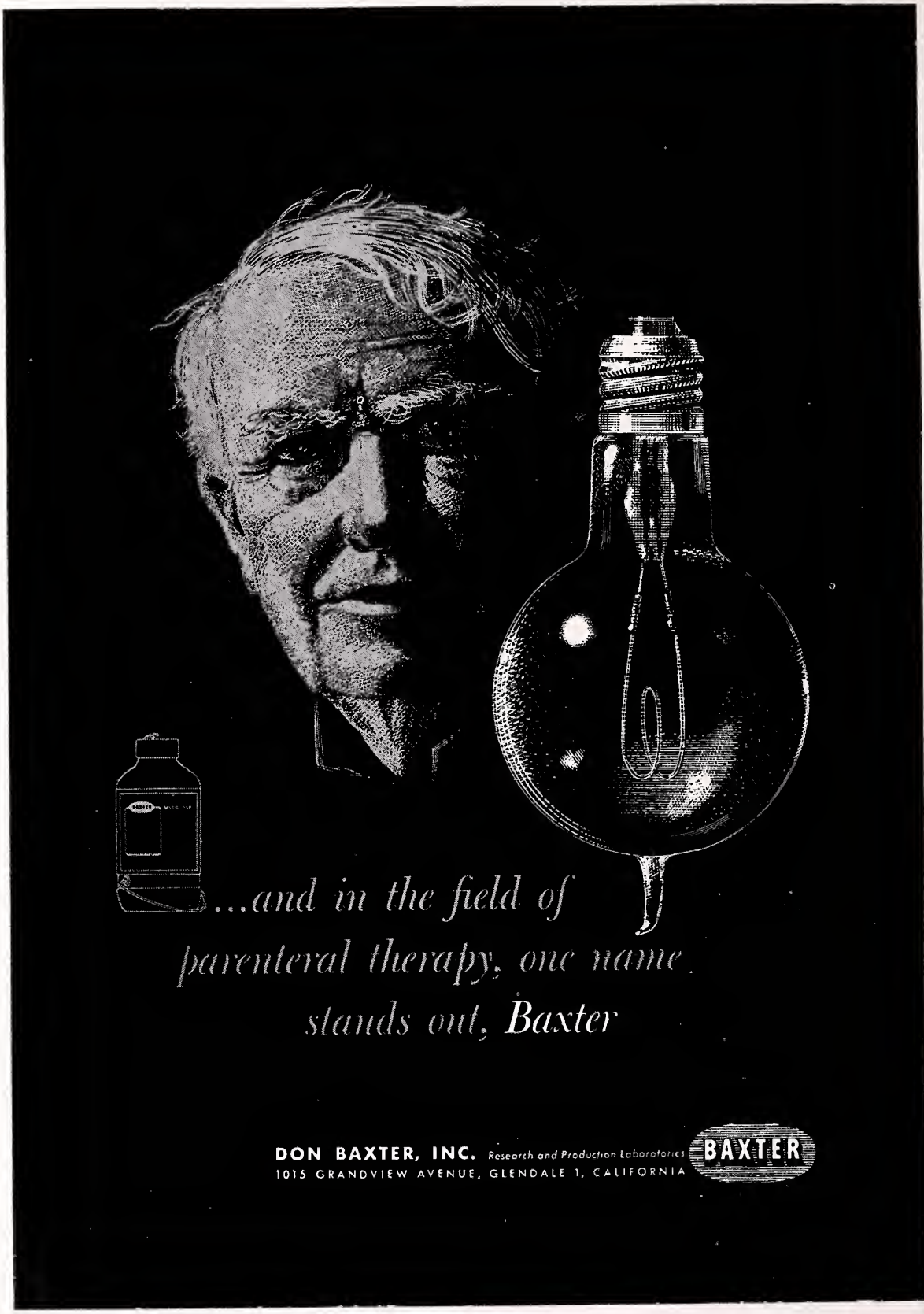
CAFERGOT SANDOZ

VASCULAR HEADACHES

Sandoz

PHARMACEUTICALS

DIVISION OF SANDOZ CHEMICAL WORKS, INC.
HANOVER, N.J. • CHICAGO 2 • SAN FRANCISCO 8



Territorial Distributor: **CROCKETT SALES COMPANY**
P. O. Box 3017 • Honolulu, T. H. • Phone 6-8992

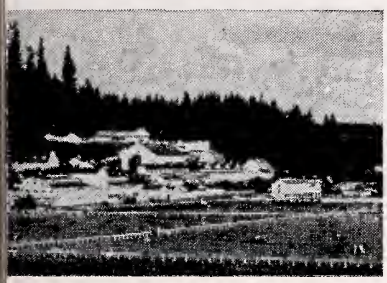
How Carnation protects the baby's formula from farm to bottle



GUARDS YOUR RECOMMENDATION 5 IMPORTANT WAYS

1. Every drop of Carnation Milk is processed solely by Carnation, in Carnation's own plants, to Carnation's high standards, assuring constant high quality and absolute uniformity.

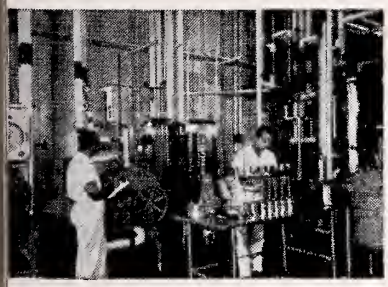




2. From the famous Carnation Farms near Seattle, cattle from world-champion bloodlines are shipped to supplier herds to help improve the Carnation milk supply.

3. Carnation supplier dairy herds and farm equipment are inspected regularly by Carnation Field Service Men. Only milk meeting Carnation's high standards is accepted.





4. In the Carnation Laboratories, continuing research guards the purity and nutritive values of Carnation Milk—develops new and improved processing methods.

5. Carnation store stocks are date coded and inspected regularly by Carnation salesmen to assure freshness and high quality whenever a mother makes her purchase.



The milk every doctor knows!

A NEW IDEA!

More and more physicians are suggesting the use of reconstituted Carnation Milk during the transition from bottle to cup, to avoid digestive upsets and encourage baby's ready acceptance of milk from the cup.





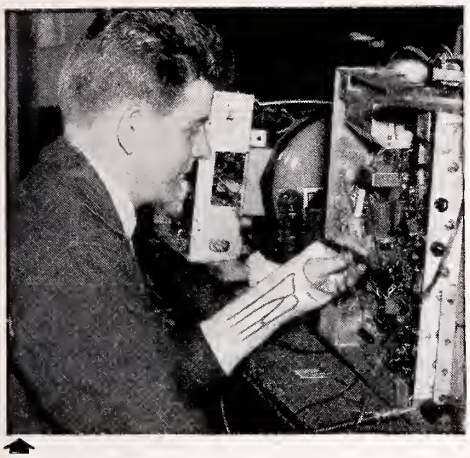
NEW MELMAC® BANDAGE provides greatly increased strength, especially in the critical early stages when ordinary plaster casts break down so easily. Bandage for bandage, MELMAC has as much *as 2 to 4 times the strength of plain plaster.*

NEW—A MAJOR ADVANCE
IN PLASTER CAST TECHNIQUE

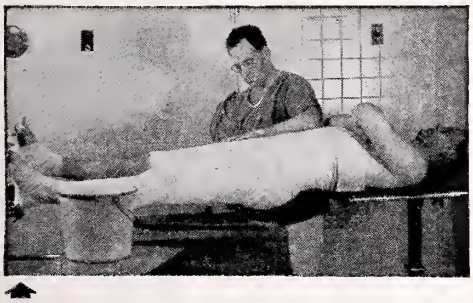
Now MELMAC® resin plaster of Paris and catalyst combined in one ready-to-use bandage.

With this revolutionary new material, MELMAC *resin* plaster of Paris BANDAGE, you can form stronger, lighter, thinner, water-and-urine-resistant casts and splints of every type and size required. There is nothing new to learn. Simply work with fewer bandages because MELMAC BANDAGE makes casts with greatly increased strength. Use it instead of plaster in fractures and preoperative, post-operative and corrective surgical procedures. 1. Just dip MELMAC BANDAGE into tepid water for 5 to 10 seconds. Squeeze out excess water *thoroughly*. Apply. 2. Use about half the usual number (or less). 3. Result: strong, light, thin water-resistant casts—no frayed edges. 4. Same disposal of waste as with ordinary plaster of Paris. 5. Remove thin cast easily with cast cutter, knife or cast saw.

PATENT APPLIED FOR



1. *More durable—to withstand hard usage on the job.* Casts of MELMAC BANDAGE take punishment of blows and sharp objects. Less need for recasting.



2. *Lighter weight—less bulk—on this 210 lb. patient.* New casts, about half the weight of plaster, encourage *mobilization of joints* to prevent stiffness. Patient easier to lift and move in hospital and at home.

HANDY-TO-USE ROLLS AND SPLINTS OF MELMAC RESIN PLASTER OF PARIS BANDAGE

Bandages (rolls)	Size	2" x 3 yds.	3" x 3 yds.	4" x 3 yds.
	Product No.	2122	2123	2164
	Size	4" x 5 yds.	6" x 3 yds.	6" x 5 yds.
	Product No.	2124	2166	2126

Splints	Size	3" x 15"	4"x 15"
	Product No.	2133	2134

Sensitivity. Since this product may contain traces of formaldehyde, persons who are known to be sensitive to it should be observed closely for dermatitis. Operators using the bandage repeatedly should wear rubber gloves if skin sensitivity exists.

BRING YOUR OLD TYPE PLASTER OF PARIS BANDAGES UP TO DATE.

Dissolve MELMAC® Orthopedic Composition, a powder, in water in which ordinary plaster bandages are wet and you will have a cast that is comparable to the new MELMAC BANDAGE cast.

3. *Less recasting—new casts resist water and urine.* Cast of MELMAC BANDAGE resists wetting and protects against other housework hazards which would decompose plaster. Washable with soap and water. *Porous,* to permit free passage of air or exudates.





4. *Thinner casts—clearer x-rays.* X-rays penetrate thin "shell" of MELMAC BANDAGE cast for clear x-ray of congenital hip, so difficult with thick plaster.



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resin plaster of Paris **BANDAGE**

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Detailed literature on request.

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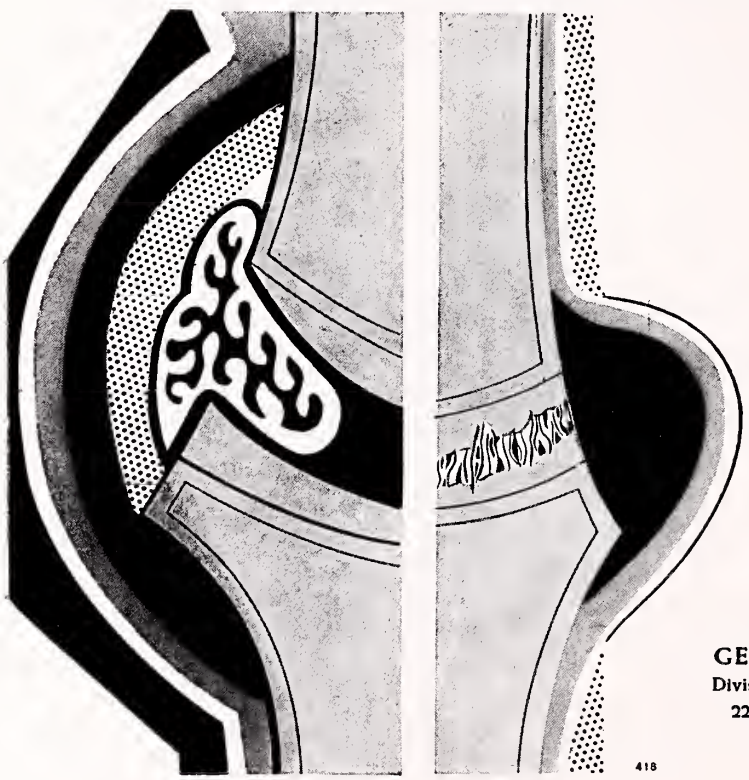
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BUTAZOLIDIN®

(brand of phenylbutazone)

nonhormonal anti-arthritic

relieves pain • improves function • resolves inflammation



415

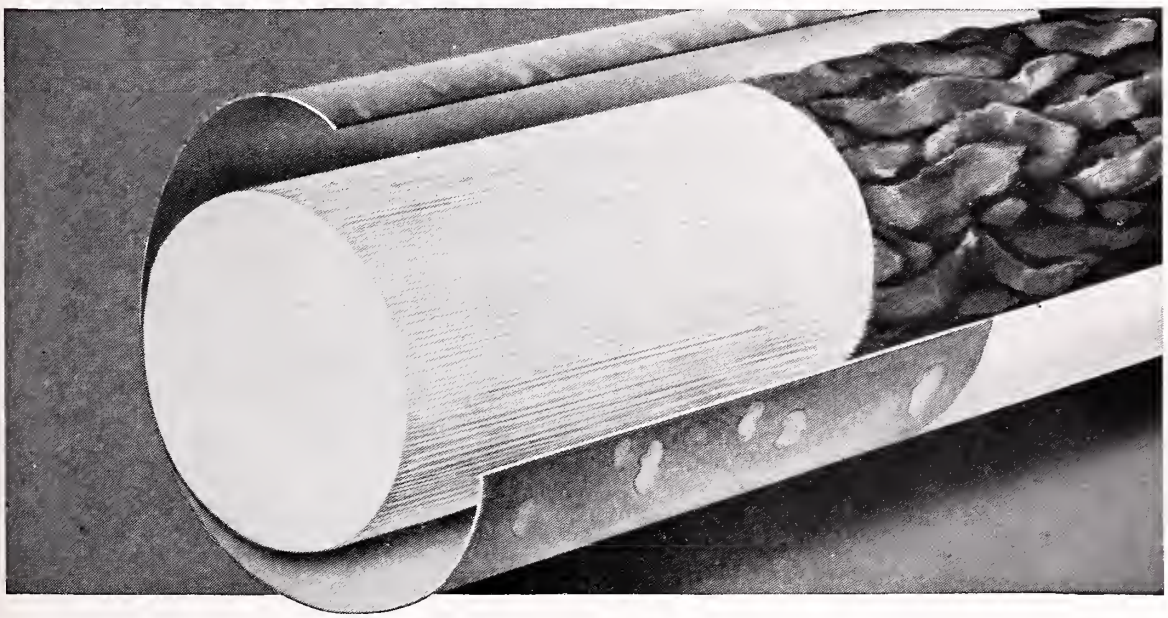
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GEIGY PHARMACEUTICALS
Division of Geigy Chemical Corporation
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Thank You, Doctor!

To the 64,985 doctors who have visited Viceroy exhibits at medical conventions . . . and to the leaders in the medical profession who smoke and recommend Viceroy Filter Tip Cigarettes . . . we'd like to say "Thanks." Your approval of Viceroy has helped establish its leadership . . . *Viceroy now outsells all other filter tip cigarettes!*

NEW VICEROY GIVES SMOKERS
DOUBLE THE FILTERING ACTION!



1. NEW AMAZING FILTER OF ESTRON MATERIAL
20,000 tiny filter elements in this new-type filter tip, exclusive with VICEROY! Made of Estron—a pure, white cellulose acetate—this non-mineral filter represents the latest development in twenty years of Brown & Williamson filter research. It gives the greatest filtering action possible without impairing flavor or impeding the flow of smoke.

2. PLUS KING-SIZE LENGTH
The smoke is also filtered through Viceroy's extra length of rich, costly tobaccos. Thus Viceroy actually gives smokers *double the filtering action* . . . to double the pleasure and contentment of *tobacco at its best!*



ONLY A PENNY OR TWO MORE THAN CIGARETTES WITHOUT FILTERS

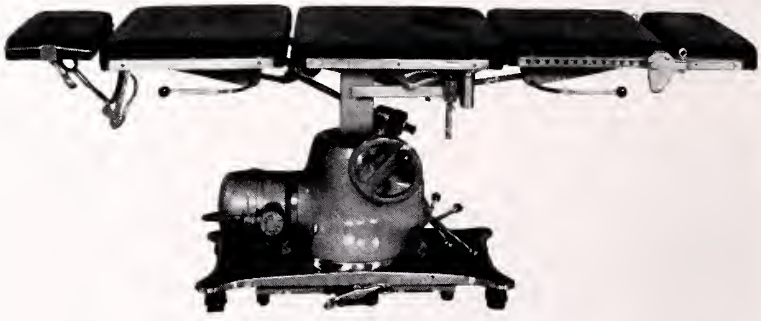


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OUTSELLS ALL OTHER FILTER TIP CIGARETTES COMBINED

Greater Flexibility...



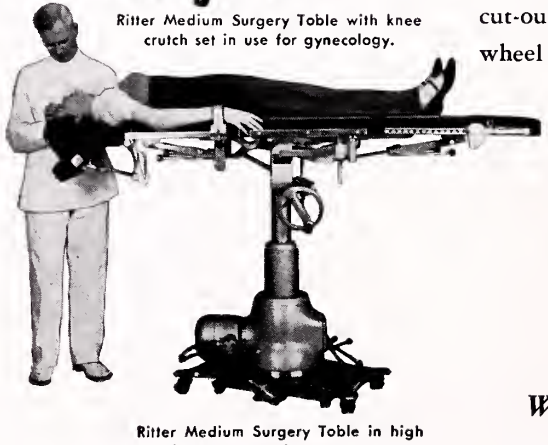


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Ritter Medium Surgery Table with strap hanger crutch set in use for gynecology.



Ritter Medium Surgery Table with knee crutch set in use for gynecology.



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The motor-elevated Medium Surgery Table moves quietly, smoothly from 26½" to a maximum of 44½" with effortless ease.

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Sulfide Suspension

(*Selenium Sulfide, Abbott*)

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Your home-owned electric utility
Bringing you better living — electrically

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rheumatoid arthritis

Cortef*



tablets

Available in:

5 mg. tablets in bottles of 50
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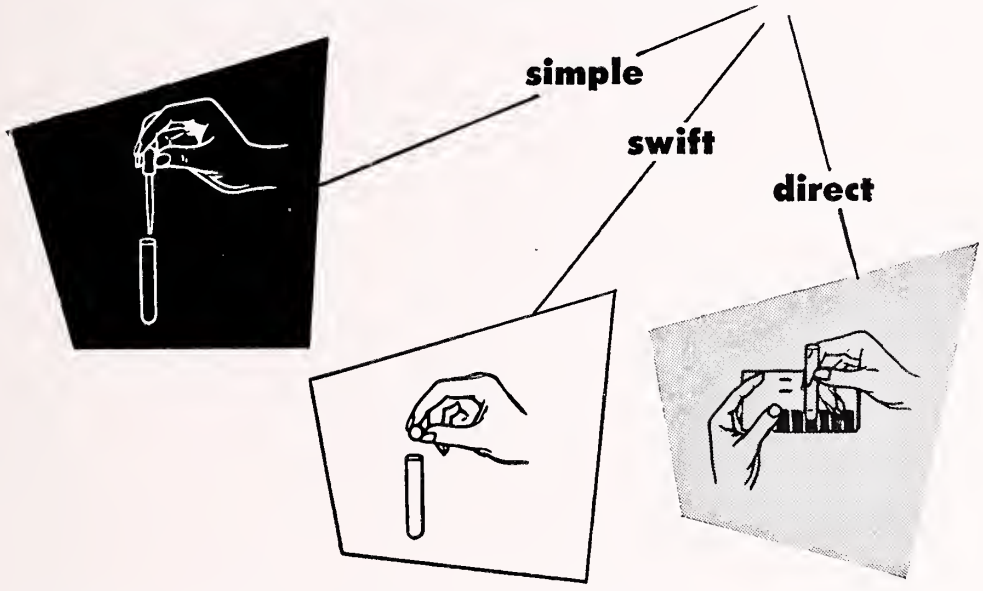
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(BRAND)

makes urine-sugar detection



Clinitest Urine-sugar Analysis Set contains all elements needed for urine-sugar determination, can be used anyplace, anytime! *Clinitest* Reagent Tablets contained in the set present a copper reduction test with all reagents compressed into a single tablet. *No external heating is required.* Each tablet generates the necessary heat. Simply drop one *Clinitest* Reagent Tablet into test tube containing proper amount of diluted urine. Wait for reaction, then compare with color scale. Ideal for doctor or patient. *Clinitest* provides a rapid, convenient and reliable test for urine-sugar. Literature available from our representative.



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MEAD'S OLEUM PERCOMORPHUM

The economical, potent vitamin A and D drops

MEAD JOHNSON & COMPANY • EVANSVILLE, IND., U.S.A.

HAWAII MEDICAL JOURNAL

and

INTER-ISLAND NURSES' BULLETIN

LUME 14 | NOVEMBER-DECEMBER, 1954 | NUMBER 2



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(ERYTHROMYCIN, LILLY)
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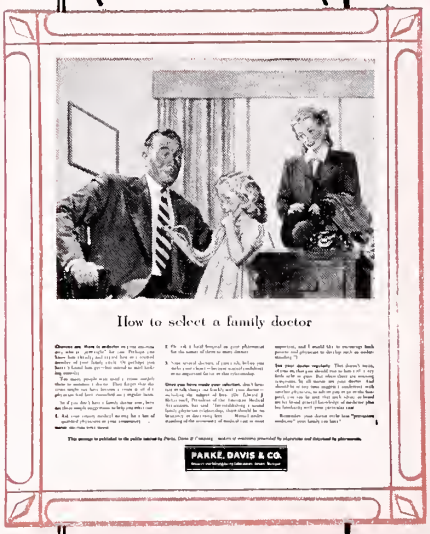
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How many of these people
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HAWAII MEDICAL JOURNAL

and

INTER-ISLAND NURSES' BULLETIN

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Number 2

NOVEMBER-DECEMBER, 1954

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35c per copy

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Mabel L. Smyth Memorial Building
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Honolulu, Hawaii, U.S.A.

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1954-1955

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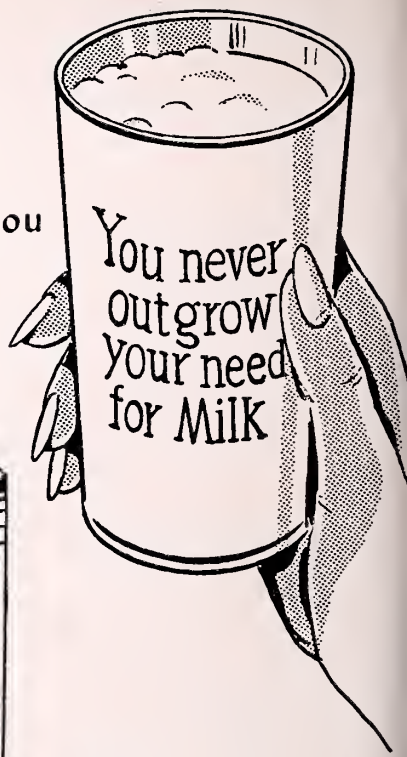
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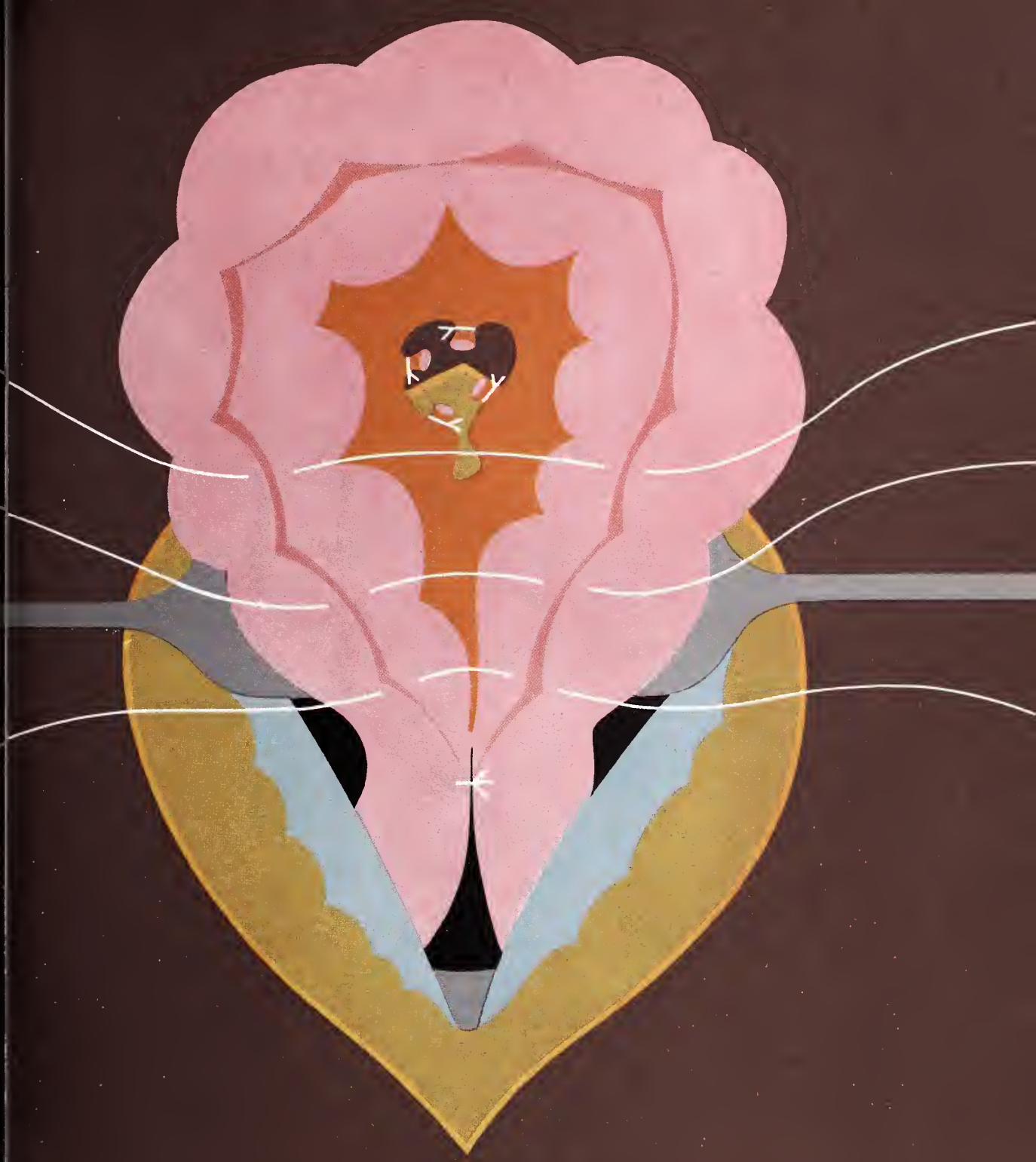
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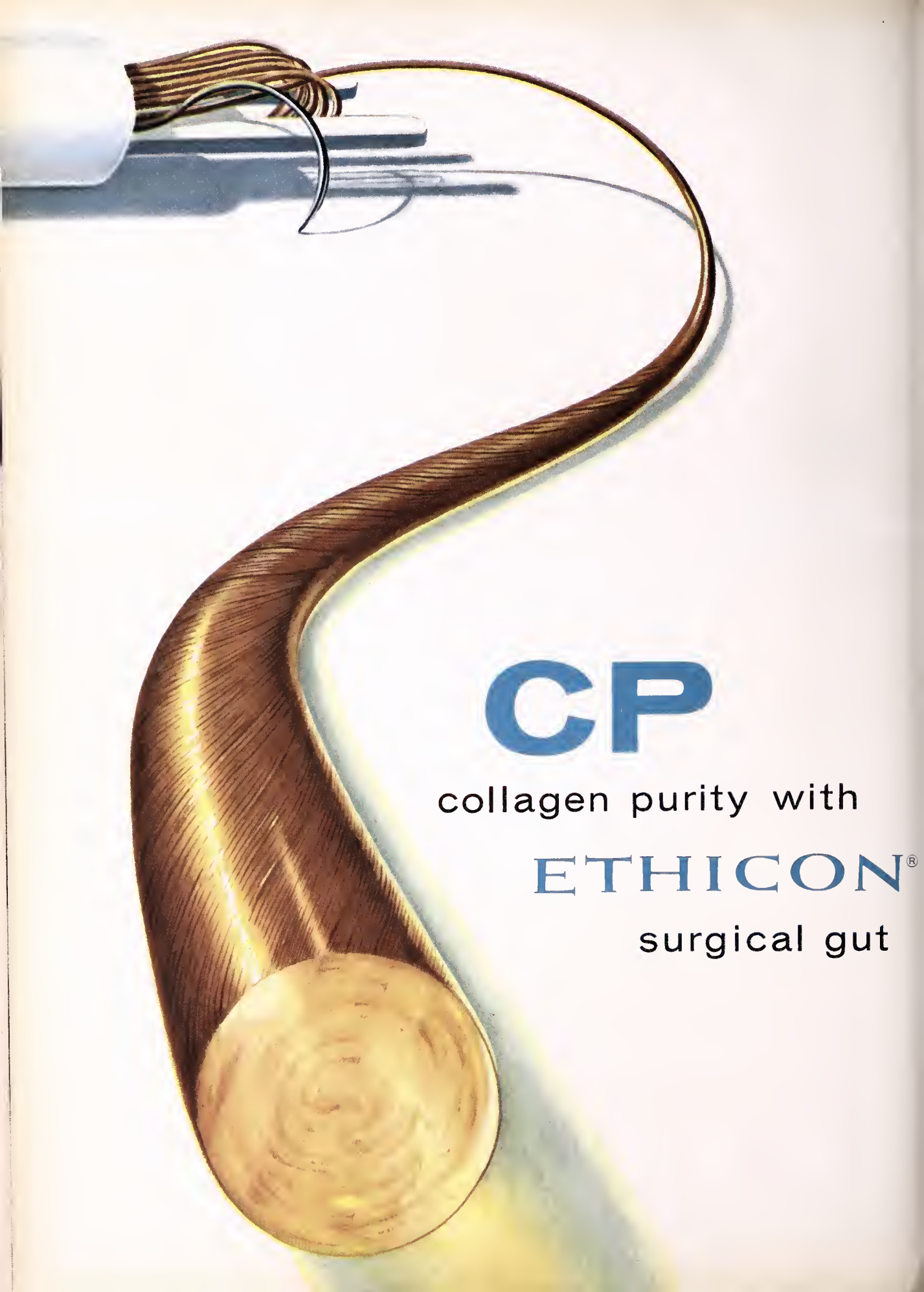
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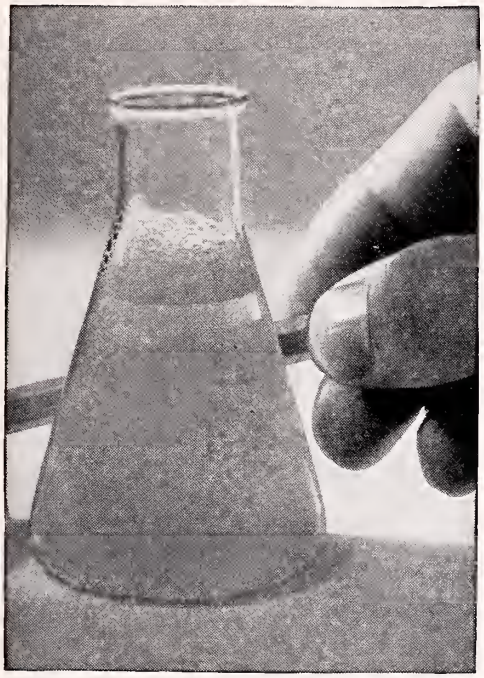
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1. *American Medical Association: New and Nonofficial Remedies, 1954. J. B. Lippincott Co., Philadelphia, p. 147*
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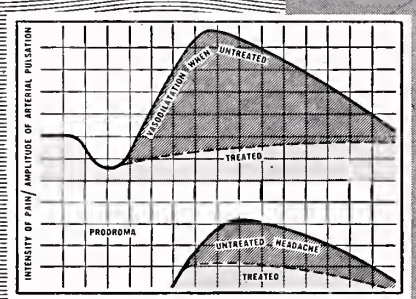
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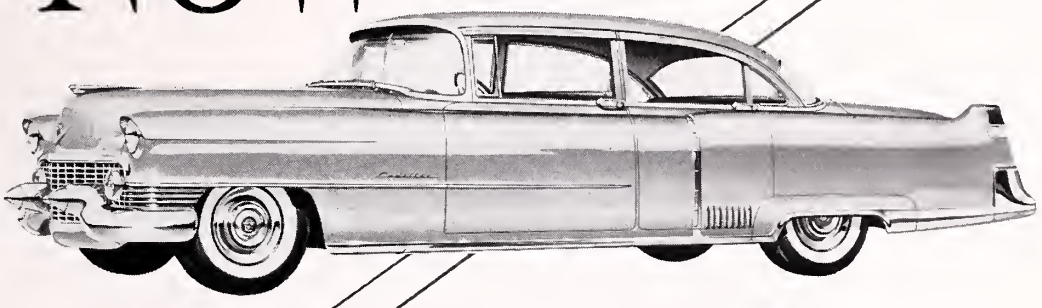
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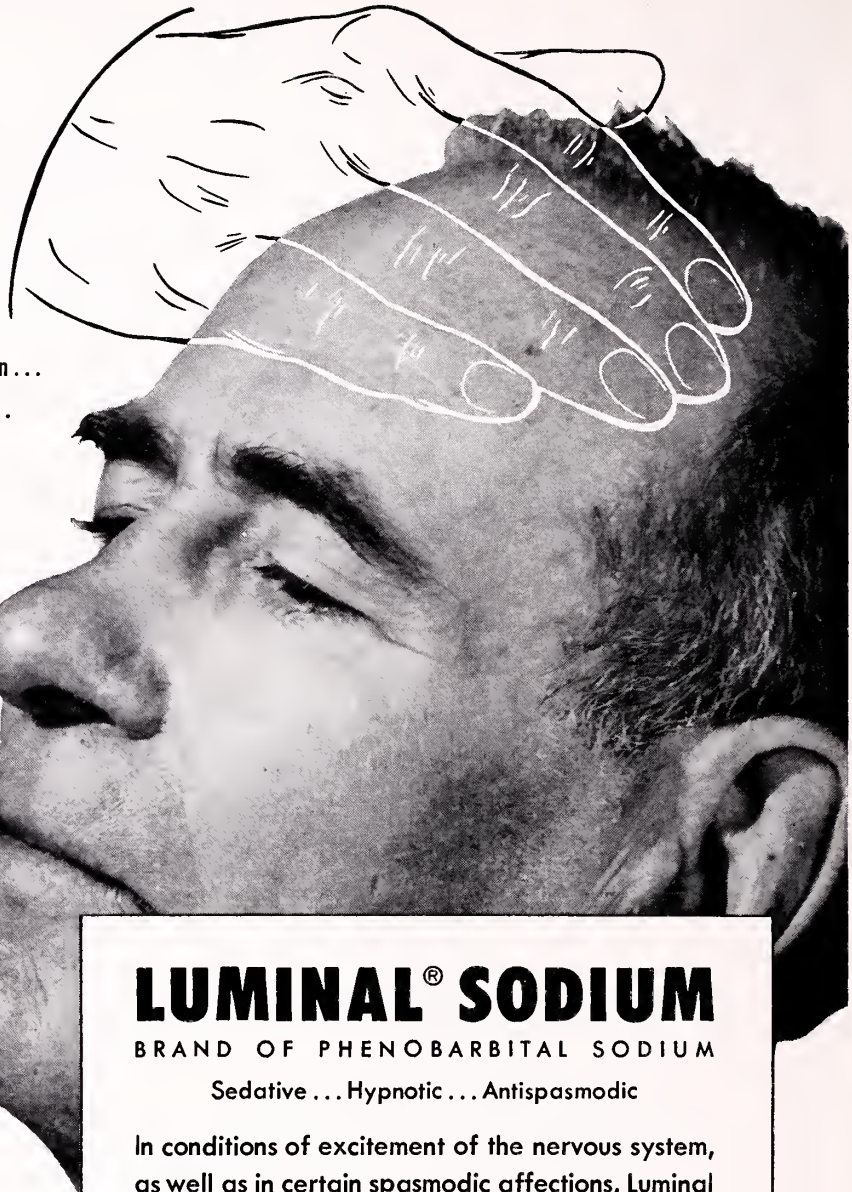
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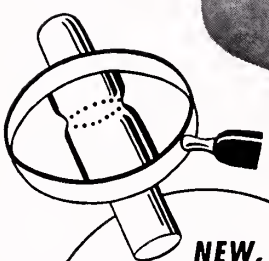
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SALMONELLA AND SALMONELLA INFECTIONS

I. Identification of Salmonella Types and Significance of Salmonella Typing

MAX LEVINE, Ph.D.,* Honolulu

WHEN most of us first became acquainted with the science of Bacteriology, the group of organisms under consideration was probably introduced by the simple generic name Bacterium which comprised all of the gram negative non-sporeforming rods. We were further informed that although there were undoubtedly a great many species, or varieties, of Bacterium, there were only a few that were really of any significance or importance—(1) the lactose fermenting Bacterium coli, which laboratory men and sanitarians used as an index of fecal contamination but which was itself supposedly non-pathogenic (i.e., as long as it remained in the intestinal tract where it belonged—a concept which is no longer strictly tenable) and (2) several lactose non-fermenting strains which were enteric pathogens and which could be quite readily recognized by certain biochemical reactions and serological properties. Among the latter were included, as you know, (1) first and foremost, the typhoid bacillus, (2) the paratyphoids (A and B) and (3) the Shiga and Flexner dysentery bacilli. Each of these organisms was biochemically and serologically quite distinct.



DR. LEVINE

All other gram negative non-sporeforming rods encountered in the intestinal tract, even when associated with active diarrheas, were generally considered to be interlopers and of no medical significance, except that they confused and thwarted the bacteriologist in his efforts to detect the recognized pathogens in samples submitted to him. It was all quite simple and it seems very difficult for many to get away from these conceptions even today.

It was a little disturbing when, in World War I, we encountered many dysentery-like cases from which we could not isolate the then recognized enteric pathogens. The explanation that these failures were due to ineptness and shortcomings of the bacteriologist and his techniques was an easily available, and readily accepted, "out" for all concerned. It was not until the late 1930's that dependable methods for isolation, differentiation and identification of enteric pathogens became available. As a result, we have emerged from a state of frustration of World War I, when only a few enteric pathogens were either recognized or accepted, to a state of confusion in World War II, when we were confronted with the possibility that several hundred distinctive bacterial types might be associated with diarrheal diseases. One naturally wonders how many of these are really significant; what proportion are merely mirages; and how can we tell them apart?

As I know that many of you (as was frankly true in my own case for a long time) have not had occasion to keep up with developments in this field, the following discussion will be presented in two parts—first, a hurried review of the basic principles underlying techniques for detection, identification and classification of the gram negative enteric pathogens, and, secondly, some practical diagnostic and epidemiological applications of Salmonella typing.

I. The Intestinal Groups of Bacteria

The intestinal tract, as is well known, is teeming with bacteria. Among the more important groups are the gram negative non-sporeforming short rods of which Escherichia coli is a typical example of an organism normally present; and such enteric pathogens as the typhoid bacillus, Paratyphoid A and B, and those responsible for bacillary dysentery, are examples of recognized pathogens. When the intestinal group of bacteria is referred to, it is these forms that we are ordinarily thinking of. However, it is desired to point out that the enteric streptococci, gram positive rods belonging to the genus Lactobacillus, sporeforming anaerobic bacilli, and anaerobic non-sporeforming gram positive rods, are normally present in large numbers in the intestinal tract. The following discussion, however, will be restricted to the gram negative rods.

To refresh your memory, Table 1 depicts what were considered the three main sub-groups of the colon-typhoid group of bacteria.

* Chief, Bureau of Laboratories, Department of Health.
Read before the Honolulu Pediatric Society, April 9, 1953.
Received for publication April 21, 1954.

TABLE 1.—*Groups of intestinal bacteria.*

GROUP	DEX. A. G.	LACT. A. G.	MOT.	UREASE	V. P.	GENUS	ILLUSTRATIVE SPECIES
Coliform	+ +	+ +	V	—	—	Escherichia	coli
			V	+	+	Aerobacter	aerogenes
Intermediate (Paratyphoid)	+ +	— —	+	+	—	Proteus	vulgaris
			+	—	—	Salmonella	cholerae suis; paratyphi (A); enteritidis
Typhoid-Dysentery	+ —	— —	+	—	—	Eberthella	typhi
		∓ —	—	—	—	Shigella	dysenteriae; paradysenteriae

The third or typhoid-dysentery group, for example, was generally considered as comprising two genera—the genus Eberthella, of which the well-known typhoid bacillus was the type species, and the genus Shigella, several species of which were associated with bacillary diarrhea. These two genera differed on the basis of motility and also antigenically. Modern investigations of the antigenic components of the various gram negative intestinal bacteria have led to the conclusion that the genus Eberthella is not valid and that the typhoid organism, for reasons to be indicated, should rightfully be considered along with the Salmonella. It has consequently been incorporated into the latter genus.

II. The Salmonella Group of Bacteria (Definition of Group)

For the purpose of this discussion, the Salmonella group of bacteria will be considered as comprising those organisms which, with few exceptions, are motile gram negative short rods; produce acid and gas from dextrose but not from lactose, sucrose or salicin; do not produce spores or indol and are not capable of utilizing urea as a source of nitrogen. These characteristics are mentioned merely to indicate the criteria which the laboratory man must utilize to separate out what he would consider suspiciously as a Salmonella from other, presently presumed non-pathogenic, gram negative non-sporeforming rods.

Having isolated an organism from a stool, body fluid, or food product, which falls into the Salmonella group on the basis of the biochemical and morphological characteristics just mentioned, it is then incumbent upon the bacteriologist to ascertain whether it is serologically a member of the Salmonella group and allocate it to a specific Salmonella type. This, at first sight, appears to be a rather complicated procedure.

III. Differentiation and Identification of Salmonella Types

A. Limitation of Simple Agglutination Titer Determination for Differentiation.

In Table 2 are illustrated the feasibility and limitations of mere agglutination titers for bacterial differential purposes. Thus the typhoid and Para A organisms might conceivably be differentiated with a high degree of reliability by determination of agglutination titers against typhoid and Para A antisera, respectively.

TABLE 2.—*Agglutination titers with antisera for specific and related salmonella.*

ANTIGEN	S. TYPHI	S. PARATYPHI (Para A)	S. SCHOTT-MUELLFRI (Para B)	S. TYPHI-MURIUM
Antiserum		*Agglutination Titer*		
S. typhi	*10,000*	400	300	300
S. paratyphi (Para A)	400	*10,000*	200	200
S. schottmuelleri (Para B)	200	300	*10,000*	*10,000*
S. typhimurium	300	300	*10,000*	*10,000*

In contrast to the foregoing, the Paratyphoid B and S. typhimurium organisms could not be differentiated from each other by determining agglutination titers with their respective antisera, for each of them is agglutinated by sera produced against the other in equally high dilution, yet, it has long been recognized that they are distinctly different organisms. To circumvent this difficulty, the technique of agglutinin absorption (first introduced by Castellani almost 50 years ago) for antigenic analysis of organisms may be effectively utilized.

B. Differentiation by Antigenic Analysis

(1) Structure of the Bacterial Cell; Location and Designation of its Antigenic Components.

When agglutinins were first visualized, they were sometimes thought of as specific for particular organisms (bacteria). It was soon realized that these agglutinins constitute specific chemical components of bacteria; that different bacteria may, on the one hand, have one or more identical antigenic components which would cause the bacteria to show relationship when tested by the agglutination technique (as, for example, is indicated by evidence of cross agglutination in Table 2) and, on the other hand, organisms might also possess *individually distinctive* antigenic components which would enable the bacteriologist to tell them apart; that is, to identify them as individual distinguishable types, or species, of bacteria.

In Figure 1 is illustrated, diagrammatically, the present concept of the location of antigenic components in Salmonella typhi and Salmonella pul-

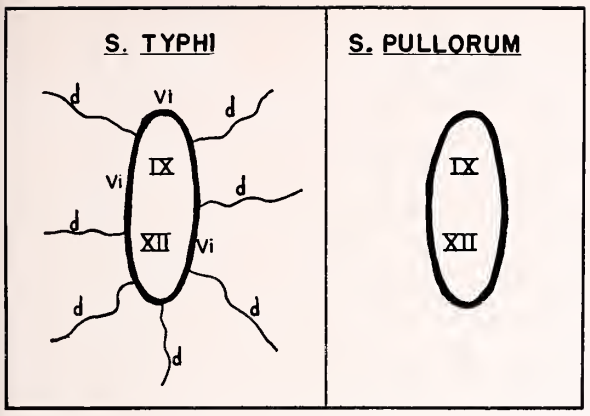


FIG. 1.—Location and designation of "O," "H" and "Vi" antigenic components.

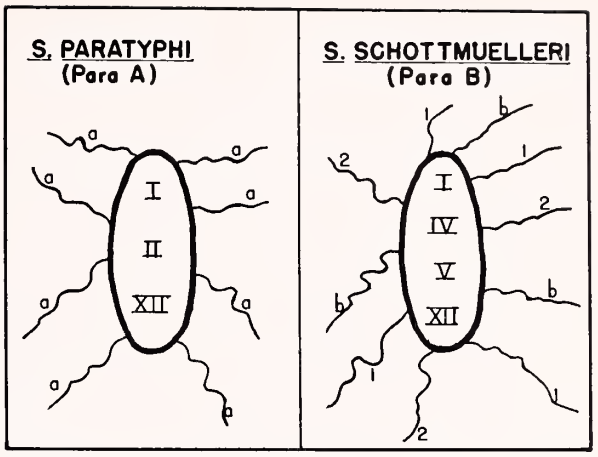


FIG. 2.—Location and designation of "O" and "H" antigenic components.

lorum. The bacterial cell consists of the body proper together with its flagella, if any. The antigenic components associated with the body and the flagella, respectively, are so characteristically different, with respect to reaction to chemicals and heat, that it has become customary to refer to the body antigens as the "O" or somatic antigens—which are indicated by roman numerals*—and the flagellar antigenic components as "H" antigens—which are indicated by arabic letters and numerals. Another component which should be mentioned is the so-called "Vi" antigen which presumably is located on the surface of the cell of the typhoid and a few other bacteria.

A few of the characteristics of these antigens are worthy of mention. Thus, the "O," or somatic, antigens are not destroyed by boiling or exposure to absolute alcohol nor by moderate concentration of formaldehyde. In contrast to this, the "H," or flagellar, antigens are easily destroyed by heat or exposure to alcohol but are not affected by moderate concentration of formaldehyde. In sera made by using formolized cultures, the concentration of "O" antibodies for somatic antigens is low whereas the concentration of "H" antibodies for flagellar antigens is very high, so that by judicious dilution antisera containing only "H" antibodies may be obtained.

In Figure 2 is shown diagrammatically our present concept of the antigenic structure of Salmonella paratyphi (Para A) and Salmonella schottmuelleri (Para B).

It will be noted that they are similar in that they both contain the somatic antigens I and XII but that somatic antigen II is distinctive for S. paratyphi (Para A) and somatic antigens IV and V are distinctive for S. schottmuelleri (Para B). It will further be noted that paratyphoid A possesses flagellar antigen "a"—which is distinctive for that particular organism—whereas in paratyphoid B there are at least three different flagellar antigens indicated by the arabic letter "b" and arabic numerals 1 and 2.

(2) Characterization of Salmonella Groups. The Salmonella strains are classified into groups on the basis of their component somatic ("O") antigens and each group is then further subdivided into a large number of "types" on the basis of their flagellar ("H") antigens (see Table 5). As may be seen from Table 5, and from Table 3 where the antigenic components of a few Salmonella types are indicated, each group has a characteristic, or distinctive, somatic "O" antigen but other "O" antigens might also be present; and that types in different groups may have common "H" antigens—e.g., S. schottmuelleri and S. newport both have "H" antigens 1; 2.

TABLE 3.—*Antigenic components (Salmonella groups).*

GROUP	SALMONELLA TYPE	"O" (SOMATIC)	"H" (FLAGELLAR) (1)	(2)
A	paratyphi (Para A)	I, **II,*** XII	a	.....
B	schottmuelleri (Para B)	I, **IV, V,** XII	b	1,2
C_1	cholerae suis	VI, **VII**	c	1,5
	montevideo	VI, **VII**	g,m,s	.....
C_2	newport	VI, **VIII**	e,h	1,2
D	typhi	**IX,** XII, Vi	d	.....

* Distinctive "O" antigen in bold type.

It will be noted particularly that the typhoid organism has "O" antigen XII in common with paratyphoid A and B. This is one reason why we now classify the typhoid organism with the Salmonella.

As of about July 1, 1952, there have been recognized 224 Salmonella types distributed among the groups as indicated in Table 4.

* The Salmonella committee has recommended that in the future the somatic antigens be designated by arabic numerals.

TABLE 4.—*Number of recognized Salmonella types.*

GROUP	"O"* ANTIGEN	NO. TYPES	GROUP	"O"* ANTIGEN	NO. TYPES
A	II	1	E_3	XIX	5
B	IV, V	37	F	XI	12
C_1	VII	38	G	XIII	9
C_2	VIII	27	H	XIV	10
D	IX	27	I	XVI	8
E_1	X	20	Other	Various	22
E_2	XV	8	Total		224

* Distinctive for group.

IV. Salmonella Types Detected in Cases and Carriers in Hawaii

In Table 5 are listed the Salmonella types which have been isolated from cases and carriers in Hawaii since 1948 together with their respective "O" and "H" antigenic components. Except for organisms of the group which have long been recognized as species—e.g., S. typhi, S. paratyphi, S. schottmuelleri, S. anatum—the various types are designated by the locality where they were first encountered—e.g., S. montevideo, S. manhattan, S. panama, etc.

V. Significance of Salmonella Typing

The question which naturally presents itself is, what is the significance and value of the Salmonella typing? It is frequently said that from the clinical standpoint all that needs to be known is that the individual is suffering from Salmonella infection and that treatment is probably the same for all Salmonella types. This may be true although the statement may well be accepted with some reservations for it is entirely possible that different Salmonella types might require different medication since they exhibit different susceptibilities to various antibiotics and particularly to intestinal flora. There is no question, however, that Salmonella typing is of value from the standpoint of epidemiology as is evident from the following.

A few months ago, there was a severe outbreak of food-poisoning in the Wahiawa area resulting in hospitalization of over a dozen individuals. They had severe diarrheas, temperature running up to 104° F. and other symptoms of a very acute and distressing nature. Examination of 14 stools submitted, resulted in the detection of Salmonella anatum in 11 of them. It was impossible to get information for epidemiological follow-up because the infected individuals refused to talk. They were all Filipinos who had recently been brought to the area from another island and who had ap-

TABLE 5.—*Salmonella types isolated from man in Hawaii and their antigenic components.*

SALMONELLA GROUP	SALMONELLA TYPE	O-ANTIGENS	H-ANTIGENS		NUMBER OF INDIVIDUALS HARBORING*
			Phase 1	*Phase 2*	
A	paratyphi (Para A)	I,II,XII	a	.....	1
B	bredeney	I,IV,XXVII,XII	l,v	1,7	12
	derby	I,IV,XII	f,g	.....	97
	saint-paul	I,IV,V,XII	e,h	1,2	4
	san-diego	IV,V,XII	e,h	e,n,z_{15}	24
	schottmuelleri (Para B)	I,IV,V,XII	b	1,2	1
	typhimurium	I,IV,V,XII	i	1,2	203
	bareilly	VI,VII	y	1,5	1
	birkenhead	VI,VII	c	1,6	46
	cholerae-suis (var. kunzendorf)	VI,VII	.....	1,5	3
C_1	denver	VI,VII	a	e,n,z_{15}	1
	montevideo	VI,VII	g,m,s	.....	193
	oranienburg	VI,VII	m,t	.....	48
	oslo	VI,VII	a	e,n,x	14
	tennessee	VI,VII	Z_{29}	.....	2
	thompson	VI,VII	k	1,5	1
C_2	gatuni**	VI,VIII	b	e,n,x	3
	manhattan	VI,VIII	d	1,5	8
	muenchen	VI,VIII	d	1,2	2
	newport	VI,VIII	e,h	1,2	8
D	enteritidis	I,IX,XII	g,m	.....	8
	panama	I,IX,XII	l,v	1,5	79
	typhi	IX,XII,Vi	d	.....	7
E_1	anatum	III,X	e,h	1,6	136
	give	III,X	l,v	1,7	4
	meleagridis	III,X	e,h	l,w	5
E_2	newington	III,XV	e,h	1,6	1
E_3	senftenberg	I,III,XIX	g,s,t	.....	2
G	grumpensis	XIII,XXIII	d	1,7	19
H	carrau	VI,XIV,XXIV	y	1,7	1
Others	adelaide†**	XXXV	f,g	.....	7
	cerro†	XVIII	Z_4Z_{23}	.....	1

† Isolated from specimens from Canton Island.
** Isolated from specimens from Christmas Island.
* Summation of the figures in this column is well above the 889 individuals detected to be harboring salmonella because two, and occasionally three, Salmonella types were isolated from about 50 individuals.

parently participated in a celebration. The matter was dropped.

About a month later there was another severe outbreak, again among Filipinos working in the Wahiawa area. With the hope that information might be developed to determine the source of this outbreak, stool specimens were submitted from 83 individuals some of whom, it was felt, had eaten together but most of them were from contacts. Naturally, it was suspected that the second outbreak was associated with the first. Antigenic analysis of the organisms isolated, however, disclosed that there was probably no relation between the two outbreaks—i.e., they probably did not have a common source for, of the 44 individuals from whom Salmonella strains were isolated, 36 were Salmonella birkenhead, a type in group C, whereas Salmonella anatum of the previous outbreak was in group E.

A 3-day old infant, in one of the local maternity hospitals, was found to be suffering from salmonellosis. The organism detected was Salmonella anatum (group E). With a view to ascertaining the possible source of infection, stool examinations were made on all of the nurses who came in contact with the ward. To our surprise two of the nurses, who were entirely asymptomatic, were found to be harboring Salmonella. The organisms, however, were Salmonella san diego (group B) and Salmonella oslo (group C). The nurses were thereby exonerated as to being possible sources of this particular case.

In the February 1, 1954, weekly bulletin of the State Department of Health of Connecticut reference is made to an outbreak of salmonellosis in a hospital where eighteen mothers and infants were affected.

These incidents illustrate not only the value of Salmonella typing but may well serve to raise the question as to whether it might not be desirable to perform routine stool examination on those associated with infants' wards, and possibly also the infants' mothers, with a view to preventing possible outbreaks in the future.

The possibility that Salmonella typing may throw some light on the role of T. A. B. vaccination as a protective measure against some heterologous Salmonella infections will be discussed in a subsequent communication on the incidence of Salmonella associated with enteric disease in children and food poisoning.

Summary

The principles of Salmonella typing are discussed and the epidemiological significance of typing indicated.

The various Salmonella types encountered in Hawaii and their frequency and antigenic components are presented in tabular form.

PHARYNGO-ESOPHAGEAL DIVERTICULA

Diagnosis and Treatment

LAURENCE M. WIIG, M.D.,* Honolulu

THIS interesting condition seems to be somewhat of a medical rarity in Hawaii. At least examination of the files at three major general hospitals in Honolulu discloses only 4 cases of this condition which have been treated surgically in these hospitals in the last ten years.



DR. WIIG

The basis for this report is the encountering of 3 additional cases in a relatively small rural community (Wahiawa) within a short span of time.

This paper will make no mention of the other types of esophageal diverticula, which include "traction" diverticula of the middle esophagus and diverticula of the lower esophagus, usually of the "pulsion" type.

Cause and Nature

Esophageal "outpouching" or "preternatural pockets" in the esophagus were first described nearly two hundred years ago, the first description being by Ludlow,[1] an English anatomist, in a letter to William Hunter. Since that time the condition has attracted the attention of a number of investigators: such men as Harrington,[2] Lahey,[3] McNealy,[4] or Sweet[5] have published descriptions of this condition.

The essential facts are that this type of diverticulum is seen primarily in individuals over 50 years of age, is three times more common in males than females, and produces symptoms on the basis of a progressive increase in size with subsequent mechanical interference with swallowing. Harrington has shown that they arise primarily in the hypo-pharynx, on either the right or left posterolateral walls, or in the midline either above or below the cricopharyngeus muscle. They are most common on the left. The stress and strain of advancing years are important factors in causing these herniations, rather than any congenital defect in this area.

The diverticulum is a true one: pathologic examination shows a muscular layer as well as esophageal mucosa.

Symptoms and Signs

The symptoms of this condition are usually quite slow in onset and gradually progress to the point where the patient seeks medical attention. In the early stages the only symptoms may be slight regurgitation in the throat, hard particles of food sticking in this area, some type of chronic "sore throat," or "phlegm." As it progresses, dysphagia and vomiting of food soon after its ingestion occur, especially upon reclining. Solid foods soon become difficult to handle and the patient takes to a softer diet. This occurs when symptoms of esophageal obstruction take place and it is at this time that the patient begins to suffer more obviously from poor nutrition with its associated loss in weight. The occurrence of noisy swallowing or gurgling sounds supervenes, and the patient frequently learns to accept this as a normal part of his existence. Larger diverticula, which extend into the thoracic cavity, may produce a variety of intrathoracic symptoms. Recurring attacks of cough, bronchitis, and even bronchiectasis may take place. Hoarseness may be present, caused by either the associated mucus in the pharynx producing a laryngitis or by actual pressure on the recurrent laryngeal nerve. The physical findings connected with this condition are related to the presence of a sac in the neck containing either food or air, which may be detected on physical examination.

Diagnosis

Diagnosis in the early stages of this condition is not difficult if it is suspected and provided the patient is subjected to roentgenologic examination. In other words, the condition should be suspected in any patient giving any symptoms suggested above, at which time x-ray pictures can be made following a barium swallow without any

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[1] Ludlow, A.: Obstructed Deglutition, From a Preternatural Dilatation of, and Bag Found in, the Pharynx, Med. Obs. Soc. Physicians, London, 3:85, 1762-1767, cited by

[2] Harrington, S. W.: Pulsion Diverticulum of the Hypopharynx at the Pharyngo-esophageal Junction, Surgery 18:66 (July) 1945.

[3] Lahey, F. H., and Warren, K. W.: Esophageal Diverticula, Surg. Gyn. & Obs., Vol. 98:1 (Jan.) 1954.

[4] McNealy, R. W., and McCallister, J. W.: Surg. Clin. North America: 71 (Feb.) 1951.

[5] Sweet, R. H.: Pulsion Diverticulum of the Pharyngo-esophageal Junction: Technic of the One-Stage Operation, Ann. Surg. 125:41 (Jan.) 1947.

preparation. It is extremely difficult to detect any sign of this abnormality on inspection of the pharynx by direct or indirect means.

The use of the esophagoscope is especially dangerous, since a number of cases of perforation of a diverticulum have been reported. This catastrophe can be avoided by always x-raying the esophagus prior to esophagoscopy.

Treatment

The only satisfactory treatment is surgical. In the past there has been much discussion in regard to the advisability of a one- or a two-stage operation. Harrington, in his extensive series of cases, has conclusively demonstrated the value of the one-stage procedure which he has carried out. Sweet, in his valuable article describing his excellent method of closure of the neck of the sac, gives credit to Dr. Charles H. Mayo for having been one of the earliest advocates of excision of the sac in one stage. Dr. Mayo's original article[6] appeared in 1910, reporting his first 8 cases. It is difficult to understand the reasoning of such master surgeons as the late great Dr. Frank Lahey, who as recently as June 1953, just prior to his death, was still a strong advocate of the two-stage procedure.

Preoperative Preparation

An attempt should be made to improve the nutritional status of the patient by whatever means are necessary in order that proper healing and recovery from the operation may take place. If it is impossible to pass a tube into the stomach for feeding purposes, and if circumstances warrant it, a gastrostomy may be carried out as a preliminary measure in cases of complete obstruction. However, with parenteral fluids, blood transfusions, and vitamins, adequate preparation can usually be carried out.

In addition to the nutritional aspects, infections in the mouth and pharynx should be eliminated insofar as is possible. Preoperative antibiotics help to prevent postoperative infection and to promote good healing.

Technique of Operation

The one-stage method described by Harrington, using local infiltration anesthesia, has proved most satisfactory in my experience and was used in the 3 cases described below. Most diverticula are approached from the left side unless the diverticulum originates on the right. Since the technique of Sweet was adopted in closing the neck of the sac, practically no cases of fistula have occurred. It has been my practice to drain the wound for forty-eight to seventy-two hours, being careful not to place the drain near the site of the closure of the esophagus.

Postoperative Care

There is still some disagreement as to how soon it is permissible to allow a patient to swallow water and liquids postoperatively. It is practically impossible to prevent a conscious person from swallowing at some time, even though nothing is permitted by mouth. For this reason small amounts of water or tea have been allowed, and have done no harm even when given soon after the operation. The major source of nourishment can best be given, however, by an indwelling gastric tube and by intravenous injections. It has been my practice to remove the Levine tube about the seventh day and allow the patient to take a full liquid diet. There is a theoretical objection to the use of an indwelling gastric tube, in that it may cause some pressure necrosis at the site of the suture line. In practice, however, this does not seem to be important.

Case Reports

CASE 1.—St. Francis Hospital Case Number A 56760. Referred by Dr. J. T. Lucas, Jr., Wahiawa. M. C., age 64, Caucasian, female, was admitted to the hospital on January 23, 1952. She had first consulted her physician nine days previously, asking for an injection of iron for her anemia. She stated that she had been treated previously by physicians on the mainland for this anemia and that was her only complaint at this time. However, after insisting upon taking a history and performing a physical examination, he elicited the information that for thirty years she had had progressive difficulty in swallowing food. Within the last six years this had been accompanied by vomiting of most of the food that she had attempted to eat, so that she had accepted this as her lot in life and did not seek any relief from these disturbing symptoms. She had consulted numerous physicians elsewhere who told her that "her tonsils were bad" and that her sore throat and difficulty in swallowing were due to this. The unpleasant gurgling sensation in the back of her throat she had learned to accept, since she had been told her tonsils had "eaten a hole in the back of [her] throat." At no time had she had an x-ray examination. For the last six years she had been unable to eat anything solid and had progressively lost weight and strength. During this time she lost weight from 210 to 128 pounds. Whenever she would lie down she would regurgitate food into her mouth and either vomit it completely or attempt to reswallow it, sometimes with success.

Physical examination at this time showed evidence of marked loss in weight but otherwise revealed a rather cheerful, optimistic, healthy appearing elderly woman. A gurgling sensation could be felt on the left side of the neck when she swallowed air, and a rather loud noise was heard on auscultation. There were a few small lymph nodes palpable in the left submaxillary region. Her pharynx showed considerable chronic pharyngitis, otherwise nothing pertinent was noted. Her heart, lungs,

[6] Mayo, C. H.: Diagnosis and Surgical Treatment of Esophageal Diverticula, Report of Eight Cases. Collected Papers of the Staff of the St. Mary's Hospital and Mayo Clinic, 33, 1910.

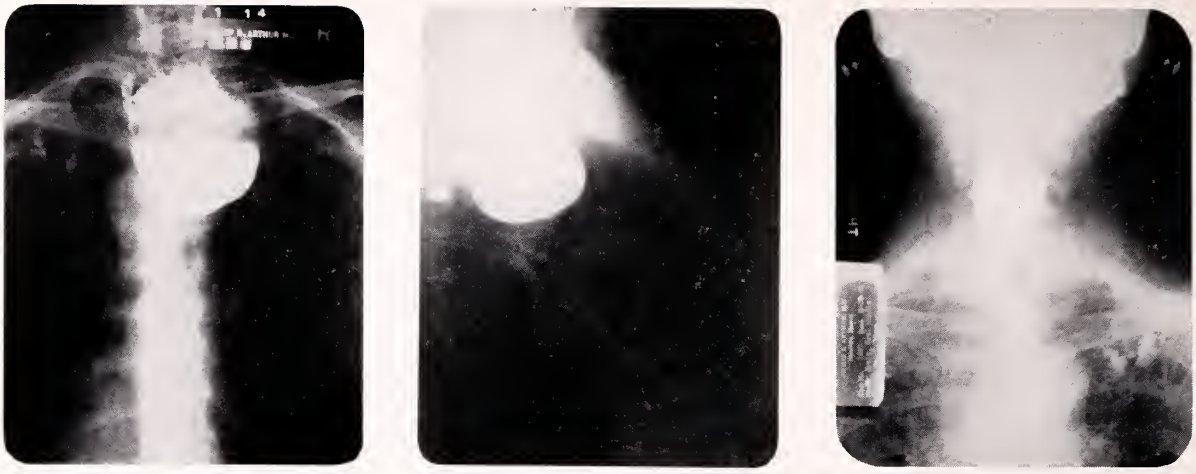


FIG. 1 A (left)—Antero-posterior view showing intra-thoracic extension of large diverticulum. B (center)—Lateral view of the same. C (right)—Postoperative film two years later shows no recurrence of the diverticulum and an adequate lumen of the esophagus.

and abdominal organs did not reveal any notable abnormalities. Her blood pressure was 104/70.

Laboratory studies showed mild anemia with 75% hemoglobin (12 gms.) and 3,800,000 erythrocytes. White blood count was 5,300 with normal differential. Urinalysis was negative. Chest x-ray showed very slight cardiac enlargement.

X-ray studies by Dr. P. S. Arthur, Honolulu, revealed a tremendous pharyngo-esophageal diverticulum in the superior mediastinum. (Fig. 1 A and B). It required nearly one quart of barium mixture to partially fill this diverticulum, and it was impossible to obtain complete filling because of the spilling into the esophagus and stomach. The remainder of the upper gastrointestinal tract did not reveal any evidence of disease. A barium enema was within normal limits.

Preoperatively the patient was placed on vitamin preparations parenterally, liquid diet, postural drainage, and penicillin-streptomycin parenterally. Intravenous fluids and a blood transfusion were administered to correct her dehydration and to improve her nutrition. An attempt was made to pass a Penrose drain weighted with mercury into the esophagus and stomach, but this was unsuccessful. Her mouth and throat were cleansed preoperatively to decrease bacterial contamination.

On January 25 she was subjected to surgical removal of the diverticulum under local infiltration anesthesia using 0.5% metycaine containing a few drops of adrenalin. The surgical procedure followed was essentially the standard one described by Harrington, with Sweet's modification in the closure of the neck of the sac. This consisted of an incision along the anterior sternocleidomastoid on the left side of the neck, dividing the platysma and omohyoid muscles. The inferior thyroid vessels were doubly ligated and divided. Following this the patient was asked to cough and the diverticulum protruded nicely into the wound, making identification very simple. The diverticulum was freed by gentle dissection from the mediastinum. Following its elevation into the wound a Levine tube was passed into the esophagus to aid in the subsequent procedure as well as in her postoperative care. The muscular and fibrous layers of the diverticulum were divided about 0.5 cm. from their junction with the esophagus and pharynx, following which the mucosa was sutured after the fashion of Sweet, alternately dividing the mucosa for a few millimeters and suturing with 4-0 silk, tying the knots in such a fashion that they were on the inside of the lumen. Following this the muscles were approximated with an interrupted row of silk sutures followed by further sutures bringing the adjacent fibrous and muscular tissues together. In view of the large dead space remaining, the mediastinum was drained by bringing two small Penrose drains out through the lower third of the wound. The wound was thoroughly lavaged with saline and closed in layers with 4-0 silk, placing some penicillin-streptomycin solution in the depths of the wound. During the surgical procedure, her pulse became irregular from traction on the vagus nerve. This was corrected by the administration of intravenous Pronestyl, 100 mg. Postoperatively her condition was satisfactory.

The pathologist reported an irregular sac-like structure showing an inner lining of mucosa resembling that of the esophagus. The wall contained very little muscle and was made up largely of edematous connective tissue.

Postoperatively the patient's course was quite uneventful. She was given steam inhalations and potassium iodine for the mucus in her throat. Five hundred cc. of citrated blood were administered on the second postoperative day; sutures were removed on the sixth postoperative day. On the seventh postoperative day the Levine tube was removed from the stomach and the patient was allowed to take liquids in increasing amounts. She was discharged from the hospital on February 2, on her ninth postoperative day and returned to her home in Wahiawa.

Her subsequent course was quite satisfactory. She was allowed to eat a soft diet in one week, and this was increased to a regular diet in two weeks. Since this time she has had no complaints whatsoever and is able to eat all types of food. She has gained fifty pounds in weight. There has been no discomfort related to her neck. A postoperative roentgenogram on April 28 showed a satisfactory lumen of the esophagus with a slight angulation (Fig. 1 C).

CASE 2.—St. Francis Hospital Case Number 65426. Referred by Dr. J. T. Lucas, Jr., Wahiawa. R. W., male, age 45, Caucasian, was admitted to the St. Francis Hospital on February 26, 1953. He first consulted his physician three days previously with a chief complaint of hoarseness of two weeks' duration and of difficulty in swallowing for about five months. His first symptom had been the sticking of food in the upper throat, followed by its backing up into his mouth, whereupon he had to reswallow it. This became progressively more troublesome, but not sufficient to cause him to lose weight or to interfere with his nutrition. Upon drinking water fast he found that it would back up into his nose. If he drank it slowly there was no difficulty. For three or four weeks he had been troubled with considerable phlegm in his throat, which was aggravated upon reclining, with regurgitation of food or liquid back into his mouth. The hoarseness began two weeks before this and was the major symptom causing him to seek medical care. He had been a heavy smoker, using three packs of cigarettes daily for years. Otherwise there was no known contributing factor to his present symptoms. He had some chronic cough, particularly at night.

Physical examination showed a very stocky, muscular, ruddy-complexioned man, who did not appear to be chronically ill. The pharynx was markedly injected but otherwise the physical examination was unrevealing. Blood pressure was 120/90. There was a gurgling sensation on palpation in the right side of his neck on swallowing air or water.



FIG. 2 A and B (left and center)—A-P and lateral views show a moderate sized diverticulum. C (right)—Postoperative film one year later shows no particular abnormalities.

Roentgenograms by Dr. P. S. Arthur revealed the presence of a moderate-sized diverticulum, arising at the junction of the pharynx and the esophagus, extending into the mediastinum (Fig. 2 A and B). It seemed to arise on, or be directed towards, the right side.

Laboratory studies in the hospital revealed a normal blood count with a hemoglobin of 84% (12 gms.), 4,780,000 erythrocytes, and 9,350 white blood cells with 55% neutrophiles, 40% lymphocytes, and 5% eosinophiles. Urinalysis was normal.

Since the patient had lost no particular weight and his general condition was quite satisfactory, he was subjected to surgery on February 27 without further preparation. This was done under local 0.75% metycaine with adrenalin local infiltration anesthesia and deep cervical field block. Because of the fact that the diverticulum presented to the right, a right sided incision was made anterior to the sternocleidomastoid. The same type of surgical procedure was carried out as in case number one. The diverticulum was found to be lying in the midline and the lower edge extended below the clavicles retro-tracheally. There were a number of large veins near the base of the diverticulum from which bleeding was somewhat troublesome. The diverticulum was attached to the junction of the esophagus by a broad base about 3 cm. in length. It was opened after circumcising the outer layers distal to this point of origin. The mucosa was closed with 3 rows of 4-0 silk as in case 1. A Penrose drain was placed in the superior mediastinum. The remainder of the wound was closed with silk. A Levine tube had been passed through to the stomach preoperatively and was left in place for postoperative feedings.

The pathologist's report on the removed specimen was "consistent with inflamed esophageal diverticulum." The microscopic sections showed squamous epithelium on the mucosal edge with a thick layer of areolar connective tissue containing smooth muscle bundles. There were numerous foci of chronic inflammation present.

The patient had an uneventful convalescence except for a temperature elevation of two degrees on the second and third postoperative days. He had some troublesome postoperative cough for which he was given expectorant drugs, iodide, steam inhalations, and antibiotics (penicillin-streptomycin). He was allowed to have sips of tea and water beginning on the day following surgery and was placed on a full liquid diet on the seventh postoperative day. The Levine tube was removed on the eighth day and he was dismissed from the hospital on the ninth postoperative day on a full liquid diet. The wound healed satisfactorily and he was permitted to eat food in increasing amounts after he returned home. He has had no further difficulty to date. A recent roentgenogram shows a satisfactory lumen to the esophagus, with a suggestion of a small outpouching below the site of the previous closure of sac (Fig. 2 C).

CASE 3.—Wahiawa General Hospital Case Number 22-756. Referred by Dr. Maurice deHarne, Wahiawa.

J. R., age 79, male, Puerto Rican, was admitted to this hospital on February 13, 1953, with a chief complaint of vomiting and coughing for eight years, which had become progressively worse. He had been in poor health for several years, suffering from frequent chest colds with repeated hospitalizations, in addition to the vomiting of partly digested food at frequent intervals. During this portion of his hospital stay he was treated for pneumonitis and pleurisy at the left base, with customary treatments, including steam, penicillin and cough medicine. Because of his debilitated condition he was given testosterone and estrone injections for their anabolic effects. When he had recovered sufficiently to permit x-ray studies, he was transported to Honolulu, where esophagus and stomach x-rays were carried out by Dr. P. S. Arthur. These revealed a pharyngo-esophageal diverticulum (Fig. 3 A and B). On careful questioning, patient noted that food stuck in his throat on many occasions and that he had a gurgling noise in his throat upon swallowing. He found that food regurgitated into his mouth daily. He also had a large amount of phlegm in his throat, and coughed, especially upon reclining.

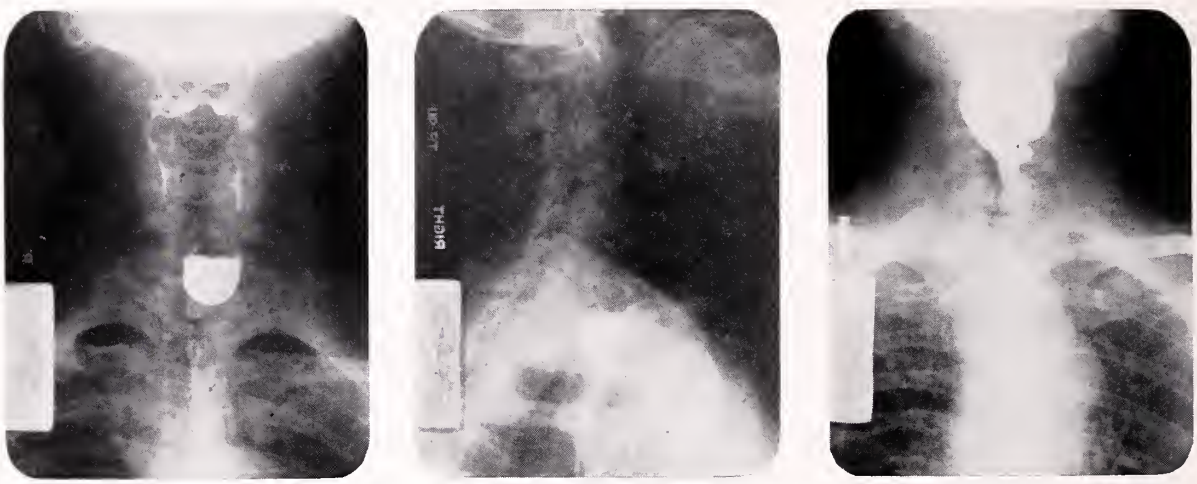


FIG. 3 A and B (left and center)—Views of a smaller diverticulum preoperatively. C (right)—One year postoperatively patient has a good lumen of the esophagus with a slight postoperative defect at site of closure.

Physical examination showed a senile, fairly well-preserved Puerto Rican man, suffering from a recent respiratory infection and some weight loss. Eyes showed senile changes. His throat was the site of a chronic pharyngitis. His neck showed no palpable masses. There was a gurgling sound and feeling on the passage of air and food upon swallowing. The chest revealed evidence of an old hypertensive heart disease with a blood pressure of 170/100; his heart was slightly enlarged and a soft systolic apical murmur was heard.

Urine was normal. A repeat chest x-ray on March 2 showed the lungs to be cleared of his recent pneumonitis. Complete blood count showed only slight eosinophilia. Hemoglobin 102% (13 gms.), 4,500,000 erythrocytes, and 9,500 white blood cells with a normal differential except for 8% eosinophiles.

He was prepared for surgery by increased food intake with a high protein diet and added vitamins, and postural drainage was instituted to aid in cleansing the diverticulum sac. Potassium iodide was given by injection. Attempts at passage of a Levine tube into his stomach were unsuccessful, since it ended uniformly in the diverticulum.

On March 5, the patient was subjected to surgery under local 0.5% metycaine infiltration anesthesia. An oblique incision was made on the left side anterior to the sternocleidomastoid muscle. The fascia was opened and the thyroid exposed, dividing the inferior thyroid vessels. The omohyoid muscle was divided and the diverticulum was easily found after having the patient cough. The sac was freed without difficulty. The neck was found to be about 2.5 cm. long and arose on the left of the midline at the pharyngo-esophageal junction.

A Levine tube was advanced into the stomach from its previous location in the diverticulum. Traction marker silk sutures were placed above and below its junction with the esophagus, following which the sac was removed and the mucosa inverted as in the previous case. A water-tight connection was established as demonstrated by the anesthetist's having the patient attempt to blow with the nose, pinched and no air escaping. A second row of sutures was taken, and two small Penrose drains were placed in the superior mediastinum after lavaging the wound with saline. The wound was closed with silk. The patient was returned to the ward in good condition.

Pathologic examination of the excised specimen showed the presence of a sac of a moderately firm nature lined by squamous epithelium. The wall was composed of striated muscle and smooth muscle. There was considerable subepithelial inflammation. A lymph node showed diffuse lymphoid hyperplasia.

Postoperatively this patient had a satisfactory convalescence, receiving penicillin-streptomycin parenterally. He was given water on the day of surgery plus intravenous fluids and vitamins. On the fifth postoperative day he was allowed to have a small amount of liquids by mouth. The sutures were removed on the sixth postoperative day. He was discharged from the hospital on March 17, the twelfth postoperative day, eating a soft diet and having no symptoms.

He regained his strength satisfactorily. His last followup examination on April 29, 1954 showed him to

be a healthy and well preserved senile person who enjoyed eating and had no further symptoms. X-ray examination at this time shows a satisfactory lumen to the esophagus (Fig. 3 C).

Comment

Case 1 was remarkable for several reasons: (1) the long duration of the symptoms (thirty years), (2) the failure of a number of physicians to recognize the condition or at least to recommend any form of curative treatment if they did recognize it, and (3) the marked loss in body weight, which certainly called for a more complete investigation than she had received prior to this time. Case 2 is somewhat unusual in that the patient was only 45, which is considerably under the average of 50 years of age, and because the diverticulum arose on the right. Case 3, the oldest in this series, being 79 years of age, had the smoothest operation and postoperation and postoperative course of any of the 3 cases and has remained in excellent health up to and including his 80th birthday recently.

Summary

A brief review of pharyngo-esophageal diverticula has been presented.

A series of three successfully operated cases occurring in a single small rural community on the island of Oahu has been presented.

The apparent rarity of this condition in Hawaii is not explainable at this time.

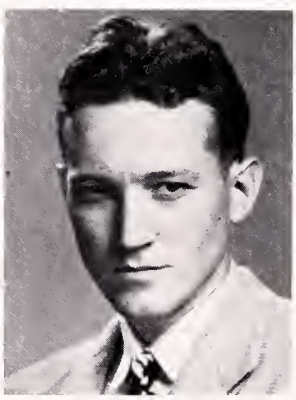
Young Hotel Building.

NEEDLE LIVER BIOPSY

Its Uses and Contraindications

RAYMOND DEHAY, M.D.,* EMIKO SAKURAI, M.D.,† AND W. HAROLD CIVIN, M.D.,‡ Honolulu

NEEDLE biopsy of the liver is a diagnostic test to supplement other well-known hepatic function tests when they, along with the history and physical examination, fail to explain the cause of the patient's liver disease. In "disease," I include frank jaundice not due to a blood dyscrasia, and enlarged liver, or any condition wherein hepatic dysfunction may play a part. This latter class includes the diagnosis of disseminated infections causing fevers of undetermined origin, as some of the etiologic agents may localize in the liver substance.



DR. DEHAY

Needle biopsy of the liver was first extensively used by Iversen[1] in Denmark fifteen years ago, and was introduced into the United States five years later. Since then it has been widely utilized.

Technique

There are two routes for securing a liver biopsy —the transabdominal and the transthoracic. The transabdominal route is suitable only for patients with livers that are grossly enlarged. It is performed with the patient lying on his back. The skin is cleansed, infiltration with a local anesthetic down through the liver capsule is done, and the biopsy needle is inserted through a small incision in the skin. It is pushed about an inch to an inch and a half into the liver, the solid stylet is removed, and the split stylet is inserted. The specimen is obtained by rotating the needle several times to break off the core of tissue at its distal attachment (Figs. 1 and 2).

The preparation is similar for the transthoracic route, but it is important to percuss out the area of liver dullness in the mid-axillary line if a satisfactory specimen is to be obtained. Using this method, one can secure a biopsy from a liver of any size. It is imperative that the patient hold his breath during the actual biopsy, since the shaft of the needle is fixed between his ribs, and the end in the liver would describe an arc during respiration, tearing the liver capsule.

Indications

As in the case of any diagnostic procedure, there are definite indications and contraindications. The indications are[1]:

INDICATIONS AND CONTRAINDICATIONS TO NEEDLE LIVER BIOPSY

INDICATIONS

1. Hepotomegaly of undetermined couse.
2. Coses in which the differentiotion between obstructive and parenchymotous joundice connot be mode.
3. Undiagnosed systemic diseose.
4. Evaluotion of suspected coses of cirrhosis.
5. Evoluation of theropy in potients with liver diseose.
6. Diagnosis of suspected coses of corcinomo of the liver.

CONTRAINDICATIONS

1. Uncooperotive patient.
2. Bleeding tendency.
3. Prothrombin concentration less than 50%.
4. Infection of skin over site of needle puncture.
5. Chronic possive congestion.
6. Undroined oscites.
7. Suspected omyloidosis.

1. Hepatomegaly of undetermined origin. This may give us the picture of a fatty liver, leading to the unsuspected diagnosis of alcoholism. A fatty liver is not necessarily due to alcoholic intake, but this is considered the commonest cause. In any case, it indicates a severe metabolic or nutritional disturbance such as is seen in alcoholism, pernicious anemia, diabetes, starvation or chronic venous congestion.

2. Cases in which the differentiation between obstructive and parenchymatous jaundice cannot be made. It is fairly well agreed that surgery in the face of hepatitis will make the patient much sicker, even if it doesn't prove fatal[2]. On the other hand, if one waits out the customary six weeks before operating on a patient with obstructive jaundice, just to give a possible hepatitis a chance

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Read before the ninety-eighth annual meeting of the Hawaii Medical Association, Honolulu, May 13, 1954.

[1] Iverson, P. and Roholm, K.: On Aspiration Biopsy of the Liver, with Remarks on its Diagnostic Significance, Acta Med. Scandinav., 102:1 (Sept. 23) 1939.

Cogswell, R. C., Schiff, L., Safdi, S. A., Richfield, D. F., Kumpe, C. W., and Gall, E. A.: Needle Biopsy of the Liver, JAMA, 140:385 (May 28) 1949.

[2] Baggenstoss, A. H. and Stauffer, M. H.: Posthepatitis and Alcoholic Cirrhosis: Clinicopathologic study of 43 cases of each, Gastroent., 22:157 (Oct.) 1952.

to show signs of regressing, the patient does not become a better surgical risk, since liver damage secondary to obstruction will be occurring during the delay. The biopsy will usually differentiate the two conditions, and the course of therapy can frequently be ascertained within the first week of the illness.

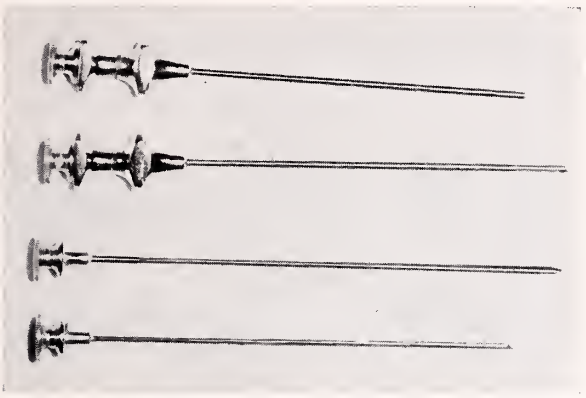


FIG. 1—Vim-Silverman biopsy needle. Above is the needle with the solid stylet in place. Below it is the needle with the split stylet in place and protruding from the end of the needle. Below this is the split stylet by itself. At the bottom is the solid stylet.

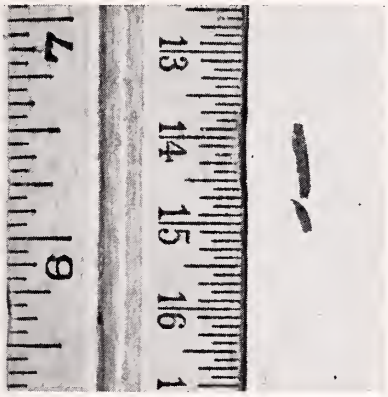


FIG. 2—This is the size of the usual specimen. It is adequate for histological study.

3. Undiagnosed systemic disease. This may prevent us from occasionally losing one of those patients with negative blood cultures and no response to penicillin or the various tetracyclines (Aureomycin, Terramycin, and Achromycin) commonly used in the treatment of patients with fevers of undetermined origin. It may show us a granuloma such as miliary tuberculosis before the pulmonary lesions have become evident by X-ray.

4. Evaluation of suspected cases of cirrhosis. Since 90% of the liver has to be non-functional before our present chemical function tests will show any abnormality, many patients with a compensated cirrhosis will give normal results. By compensated cirrhosis is meant that at least 11% of the patient's liver functions normally. These patients make very poor surgical risks as the trauma of the anesthetic and the operation may cause hepatic decompensation with jaundice and ascites appearing early in the postoperative period.

5. Evaluation of therapy in patients with liver disease. The implications of this are obvious in the handling of an alcoholic member of a family, particularly if the liver damage is of such a degree as not to cause abnormal function tests.

6. Diagnosis of suspected cases of carcinoma of the liver. One arrives at this diagnosis by hitting the nodule palpable through the abdominal wall. Failing in this, the normal liver specimen obtained from a grossly jaundiced patient with no blood dyscrasia is strongly suggestive of a carcinoma involving the liver. It assures the surgeon the patient does not have hepatitis, and an operation, if desired, may be undertaken to see if partial hepatectomy will benefit the patient.

Contraindications

As with any procedure, there are also definite contraindications.

1. The uncooperative patient is certainly no candidate for a procedure involving the penetration of a highly vascular organ by a trocar. Cooperation is extremely important if one uses the transthoracic route, lest a laceration of the patient's liver result from his failure to hold his breath during the procedure. The transabdominal approach only requires that the patient remain in one spot on the bed.

2. Any bleeding tendency makes biopsy a dangerous procedure, since the liver is such an extremely vascular organ. A careful history and a capillary fragility determination will pick up most bleeders. To test the patient for increased capillary fragility, keep a blood pressure cuff inflated on his forearm midway between his systolic and diastolic pressure, for eight minutes. In the absence of over ten petechiae in a circle one inch in diameter on his forearm just distal to the antecubital fossa, the test is negative, and no increased blood vessel fragility is present.

3. A prothrombin level of less than 50% may in itself lead to bleeding, and is an absolute contraindication.

4. Infection of the skin over the site of the needle puncture makes the procedure hazardous, by introducing organisms into the liver, from which they may rapidly enter the blood stream, giving rise to either a bacteremia or a septicemia.

5. Chronic passive congestion is a relative contraindication. The danger lies in the fact that

venous congestion from heart failure makes the liver more likely to bleed. However, if it's a problem of differentiating a carcinoma from a hepatitis, the risk is justified when no other test will give the answer.

6. Undrained ascites makes needle biopsy both hazardous and unsatisfactory: hazardous, because a loop of bowel may float up between the abdominal wall and the liver, and an undesired bowel puncture may occur; unsatisfactory, because the liver may float away from the biopsy needle. Preliminary paracentesis will circumvent this problem.

7. A massive amyloid liver occasionally splits open if a needle is inserted into it. In the presence of splenomegaly, albuminuria, and a long-standing infection or rheumatoid arthritis, a Congo Red test should be done first. If positive, there is no need for liver biopsy to establish the diagnosis. (Normally, over 60% of the dye should remain in the serum sixty minutes after injection.)

Discussion

Naturally, all of you will wonder just how safe this diagnostic procedure is. It is safer than the giving of a blood transfusion[3] if the contraindications are observed. Many series of several hundred cases report a zero mortality[4] . Terry in England recently summarized the world reports on the mortality and morbidity of needle liver biopsies. The mortality figure was about one in a thousand. The unfortunate results usually occurred early in all authors' series, while they were perfecting their techniques or when the biopsy was done in the face of definite contraindications.

In the 38 cases done in Honolulu by the authors during a sixteen month period there have been no deaths.

The morbidity has been around 0.34% in the world literature. The complications consisted mainly of post-biopsy bleeding, with an occasional instance of bile leakage, pneumothorax, or colon or renal biopsy. Most patients with post-biopsy bleeding responded to immobilization in bed, with transfusions when indicated.

The procedure is definitely safer than a laparotomy, as the trauma of surgery may precipitate acute liver failure in patients with hepatitis or cirrhosis[2].

Just how well does the biopsy correlate with the other liver function tests? Liver cell damage or extensive inflammatory changes cause abnormal flocculation or dye excretion tests[5]. Ninety per cent of the liver has to be diseased before these tests become abnormal. However, a fatty liver with no other changes gives normal function tests, even in the presence of jaundice. It is in cases of this sort that the biopsy proves of greatest value in avoiding an unnecessary major surgical procedure. Ordinarily the function tests alone, correlated with the history and physical examination, will differentiate surgical from medical jaundice in 90% of all patients.

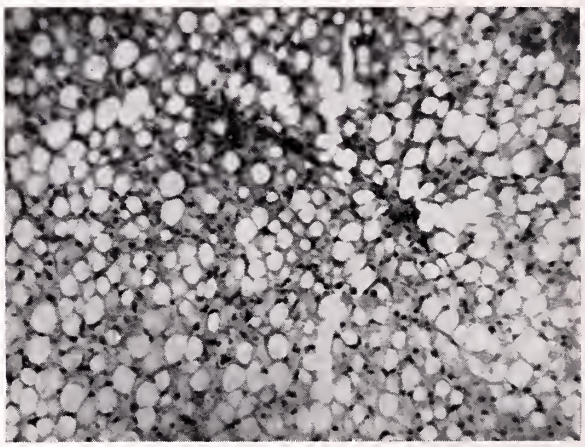


FIG. 3—Grade IV fatty change: involvement of much of liver by fatty metamorphosis. Nuclei not prominent. Compression of adjacent structure. Some lymphocytic infiltration. H & E, X90.

Case Reports

Here are four cases from the 10% of patients that could be properly evaluated only after the study of a biopsy specimen.

CASE 1. (M. M.) This patient was a 28-year-old housewife who had had repeated bouts of vomiting, diarrhea, and weight loss since 1952. Several of these had been so severe as to require hospitalization for rehydration. She gave a history of having eaten a good diet, and the only remarkable physical finding was the fact that her liver extended four fingerbreaths below her right costal margin at the anterior axillary line.

Her liver function studies were entirely normal: BSP, no retention at 45 minutes; cephalin flocculation, 0 at 48 hours. After some discussion, we biopsied her. To our surprise, we found a fatty liver, like that seen in alcoholics (Fig. 3). Further direct questioning of the patient and the family then brought out the fact that she was drinking at least a pint of wine a day, and wasn't on the diet she had outlined. This case points out what can sometimes be learned by biopsy of a liver that is enlarged, yet functions sufficiently well to give normal chemical function tests.

[3] Soutter, L.: Personal Communication to Author.

[4] Terry, R.: Risks of Needle Biopsy of the Liver, Brit. Med. Jour., 1:1102 (May 24) 1952.

[5] Waldstein, S. S., Popper, H., Szanto, P. B., and Steigmann, F.: Liver Cirrhosis: Relation between Function and Structure Based on Biopsy Studies, Arch. Int. Med., 87:844 (June) 1951.

Popper, H. and Schaffner, H.: Laboratory Diagnosis of Liver Disease: Coordinated Use of Histological and Biochemical Observations, JAMA, 150:1367 (Dec. 6) 1952.

CASE 2. (W. B.) This 84-year-old man had a carcinoma of the prostate removed on April 12, 1953. He had been given 5 mg. of stilbesterol daily ever since, as complete removal of the lesion had not been achieved. During the prostatectomy he had received one unit of blood. The last week in July, approximately three months following the transfusion, he noted mild anorexia and jaundice. The patient was hospitalized August 19, 1954, at which time his liver extended one fingerbreadth below the costal margin at the anterior axillary line, and was mildly tender. His liver function studies showed a marked impairment of function: total bilirubin, 12 mg., direct 1.6 mg%, and indirect 10.4 mg%; zinc sulfate turbidity of Kunkel, 78 units; thymol turbidity, 29 units; and serum alkaline phosphatase, 14 Bodansky units.

Despite tests pointing to parenchymatous disease, the patient's liver was biopsied because of persisting acholic stools, though it was recognized that acholic stoods do occur with serious liver damage as well as obstruction. The specimen unequivocally showed an obstructive jaundice (Fig. 4).

The surgeon explored this patient with the intent of doing a side-tracking operation. To everyone's surprise, only an inflammatory mass of nodes was obstructing the common duct. Therefore, it was dilated, and a T-tube inserted. In this case biopsy was used to settle the problem of a surgical versus a medical jaundice within a week of the patient's admission to the hospital.

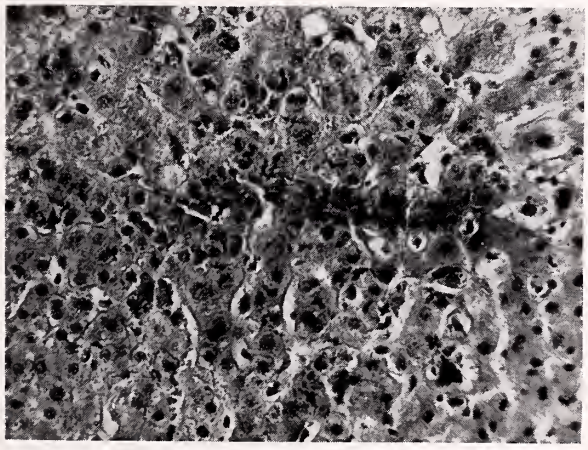


FIG. 4—Obstructive jaundice. Bile thrombi prominent. Bile staining of cells. Increased granularity of cells. Bile canaliculi dilated. H & E, X100.

CASE 3. (H. B.) This man, who operated a cleaning establishment, began to complain of right upper quadrant pain which had no relation to meals or bowel habits. An enlarged liver had been noted one year previously when the patient was treated for a left lower lobe pneumonia. He had been exposed to volatile organic solvents almost daily for the past twenty years. He was a social drinker.

Function studies done in July, 1953 were borderline abnormal: icterus index, 16 units; cephalin flocculation, three plus in 48 hours; urinary urobilinogen positive at 1:40; BSP, 2% retention at 45 minutes; and serum alkaline phosphatase, 2 Bodansky units. A needle liver biopsy at this time showed evidence of definite liver damage (Fig. 5). After several weeks of bed rest, the patient returned to work asymptomatic, and was instructed to work only at the receiving desk.

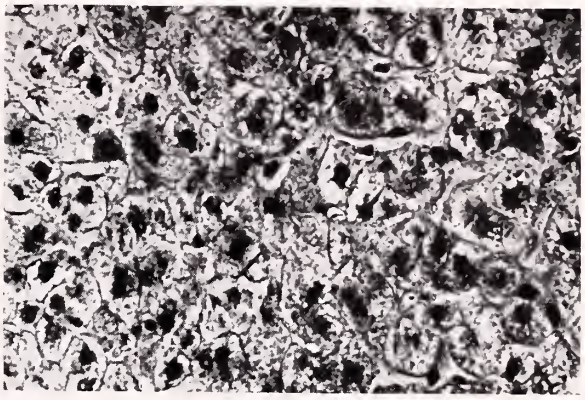


FIG. 5—Grade I-II parenchymal change. Cells vary in size. Nuclei vary in size and are very prominent. Increase nuclear-cytoplasmic ratio. Distinct cell boundaries. Cytoplasm clear to markedly granular with clumping. This is at a higher power than the others in order to accentuate some of the finer points. H & E, X250.

By March, 1954 all symptoms had recurred. Questioning brought out the fact that although he hadn't had a drink, he had gradually returned to doing spot-cleaning. At this admission his function tests were all normal: BSP, 3% retention in 45 minutes; cephalin flocculation, 4% (normal is up to 25%); zinc sulfate turbidity of Kunkel, 4.5 units; and a 24-hour urinary urobilinogen failed to show any present. It was suspected that the latter test represented a laboratory error. An x-ray of the gall bladder showed excellent visualization and contractility. A repeat liver biopsy shows definite evidence of damage again despite improved function tests (Fig. 6). Biopsy in this case showed the functional tests to be misleading us, and agreed with the patient's clinical status.



FIG. 6—Grade III change. Large fatty globules present. Marked variation in nuclear and cellular size and shape. Granularity of cytoplasm, marked. H & E, X60.

CASE 4. (W. H.) This 45-year-old man entered the Territorial Hospital (for nervous and mental diseases) actively hallucinating and deeply jaundiced, later giving a history of a heavy alcoholic intake in the past twenty years. In the last two years he had been jaundiced over six times. His liver was hard, regular, and extended four fingerbreadths below the costal margin at the

anterior axillary line. His function tests were not at all characteristic of the cirrhosis that was diagnosed clinically: thymol turbidity, 5.4 units; zinc sulfate turbidity, 2 units; van den Berg (total bilirubin), 41 mg%; prothrombin level, 62%; serum albumin, 3 gm%; globulin 2.6 gm%; and serum alkaline phosphatase, 13 Bodansky units.

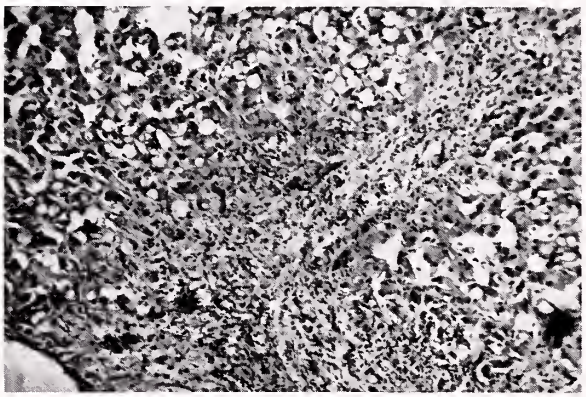


FIG. 7—Cirrhosis. Fat in cells. Fibrous tissue cutting off nests of fatty cells. Inflammatory cell infiltration and marked fibrosis, periportally. H & E, X60.

In view of the picture, the question came up, "Does this man have a malignancy of the liver?" The odds were certainly in favor of a cirrhosis, but a superimposed hepatoma could not be ruled out. Were it just cirrhosis, a laparatomy would not improve the patient's clinical situation in the least. Accordingly, a biopsy was performed. At the time of the biopsy the liver felt like a piece of leather, settling the question as to the fact that cirrhosis was definitely present, normal function tests or not (Fig. 7). In this patient the biopsy definitely ruled him out as a surgical candidate, as a partial hepatectomy is not tolerated by patients with cirrhosis.

Summary

Needle liver biopsy, when properly used, is a safe diagnostic procedure that supplements other diagnostic aids.

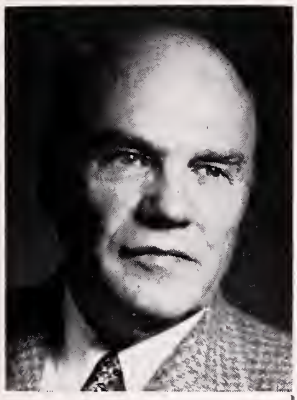
It is of value in diagnosing not only primary liver disease, but also in picking up systemic infections, particularly miliary tuberculosis before it has become evident on the chest x-ray.

7 Kihapai St., Lanikai

ATHEROSCLEROSIS—AN AUTOPSY STUDY

NILS P. LARSEN, M.D., Honolulu

IN recent years, there has been an intense search throughout the world to determine the reason for and the nature of atherosclerosis. In various laboratories, atherosclerosis (the most common form of arteriosclerosis) has been produced experimentally in many different animals. Cholesterol and the fat in the diet have been blamed most frequently. Female hormones, choline, inositol, methionine, etc. have been recommended as preventives of this process, but the scientific storm still rages as to the importance of these different factors. Is diet really a factor? Is stress? Is heredity? Is it nephritis, toxic agents or an imbalance of the endocrines?



DR. LARSEN

Since in Hawaii we are living in an amazing test tube where climatic stress is at a minimum, social stress far less than in most places, and eating habits of significant numbers of our citizens very different, it was thought that possibly a contribution could be made by analyzing our postmortem atherosclerotic findings.

Walter Bortz of the University of Pennsylvania during the summer of 1953 recorded the amount of atherosclerosis found in a consecutive series of 1250 autopsies at The Queen's Hospital in patients over 30 years of age. Dr. Harold Civin helped throughout the study and evaluated the statistical significance of the findings. Mr. George H. Tokuyama arranged for the statistical tabulation on the IBM machines of the Board of Health. No attempt was made to evaluate the blood vessel condition in relation to the cause of death. The tabulation was merely to indicate the amount of atherosclerosis present in the coronaries of people who died of numerous causes. The degree of atherosclerosis was tabulated in five categories.

The 1st group showed no atherosclerosis; the second group had minimal lesions. For the graphs, these two were lumped as having no or little atherosclerosis. The third group showed definite but not serious changes. The fourth group showed definite narrowing and diffuse sclerosis, and the fifth group showed advanced sclerosis with plaques, occlusions and ulcerations. The fourth and fifth groups were lumped together as severe atherosclerosis. All the deaths were also tabulated by age groups of those under 45 and those over 45. The actual collection of data was made in increments of each five years of age for each nationality.

The accompanying tables and graphs were made from the recorded findings.

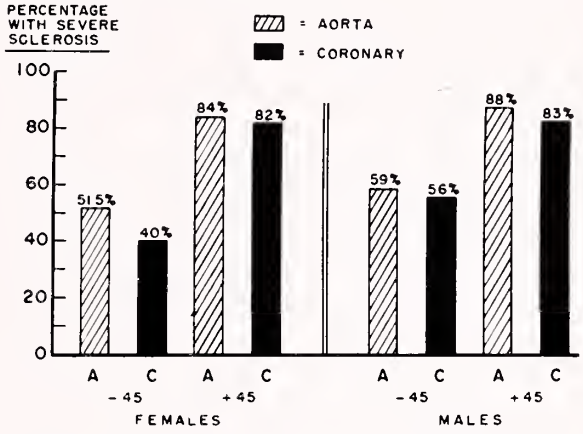


FIG. 1—Sex and Age Factors in Atherosclerosis (Females vs. Males).

TABLE 1.—*Sex and Age Factors in Atherosclerosis, Medium to Severe in Females vs. Males.*

TOTAL 1250	446 FEMALES vs. 804 MALES
UNDER 45—Females had 101 cases	
52 of these had def. sclerosis,	
of aorta (3.4.5)	51.5%
of coronary (3.4.5)	40%
OVER 45—Females had 345 cases	
286 of these had def. sclerosis,	
of aorta (3.4.5)	84%
of coronary (3.4.5)	82%
UNDER 45—Males had 142 cases	
83 with def. sclerosis,	
of aorta	59%
of coronary	56%
OVER 45—Males had 662 cases	
580 with def. sclerosis,	
of aorta	88%
of coronary	83%

Age and Sex

It is evident from Table 1 and Figure 1 that age is a definite factor. With rising years the amount of atherosclerosis increases. Forty per cent of all females between 30 and 45 had severe coronary atherosclerosis, but 56% of the males had similar severe lesions. In patients over 45, 82% of the females and 83% of the males had severe coronary atherosclerosis. After the childbearing period, apparently the difference between male and female becomes negligible. It was also evident that there is more severe atherosclerosis in the aorta than in the coronary.

From the Department of Internal Medicine of The Medical Group.

Read before the ninety-eighth annual meeting of the Hawaii Medical Association, May 13, 1954.

Race

Figure 2 suggests rather interesting differences. It will be noted that a higher percentage of the Caucasian females were free of sclerosis under 45 (not of statistical significance) but a much higher percentage of the arteries of Oriental females above 45 were free of sclerosis. In males under 45, there is little difference between the two groups, whereas over 45 there is a striking difference in the number of Orientals who were free of sclerosis and the fewer who had severe sclerosis as against the Caucasians in the same age groups. Considerably more sclerosis is found among Caucasian men than among Orientals in the over 45 age group. In females over 45, severe sclerosis is distinctly more marked among the Caucasians. Diet is one of the biggest differences in these two groups, and the diet difference is greater in the older people since the young Orientals are eating more and more Caucasian food.

Figure 3 on Hawaiians and Part-Hawaiians is based on fewer cases than the graphs of the other groups and is, therefore, of less value. However, it is of interest to show that among Hawaiians and Part-Hawaiians there are fewer females over 45



FIG. 2—Coronary Atherosclerosis (Oriental vs. Caucasian).



FIG. 3—Hawaiian and Part-Hawaiian in % Atherosclerosis.

without sclerosis, and more females over 45 with severe atherosclerosis, than in any other group. Among the Hawaiian males, however, there is a higher percentage of males free of sclerosis, and the percentage with heavy sclerosis falls between the Oriental and the Caucasian. The Hawaiian women definitely tend to become fatter than any other group. These figures might help to point in the direction of the fat person as having more atherosclerosis, and that diet may be an important causative factor.

TABLE 2.—*ACP Study—Over 30 Years of Age.*

TOTAL	5,010	
Males	2,405	
Females	2,605	51%
Caucasian	3,290	
Oriental	1,720	34%
ARTERIOSCLEROTIC HT. DIS.		
Oriental		20%
OBESITY		
Oriental		15%
HYPERTENSIVE CASES		
Oriental		51%

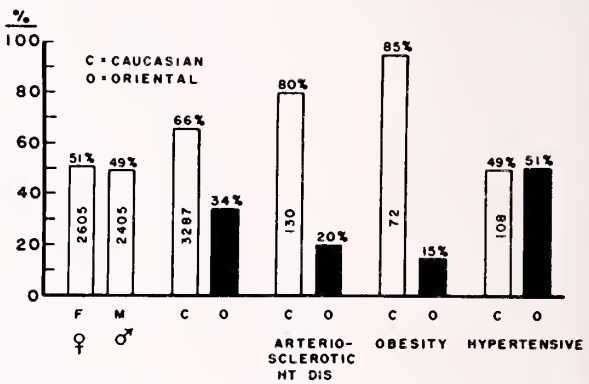


FIG. 4—Office Study of 5,010 Patients over 30 Years of Age (A. C. P.).

A clinical study was made by the members of the American College of Physicians in Hawaii on 5,000 consecutive office patients over 30 years of age. The findings are tabulated in Table 2 and Figure 4. There were fewer Orientals than Caucasians diagnosed as suffering from arteriosclerotic heart disease. Note also that fewer Orientals came in for obesity. (The number on each bar indicates the number of individuals). On the other hand, there were more Orientals who were diagnosed with hypertension. The total number of cases of hypertension, of obesity and of arteriosclerotic heart disease are relatively few in relation to the total number who came to the doctor's office for advice. This relative rarity is in sharp contrast to the very common occurrence of atherosclerosis in the autopsy findings at all ages. It suggests that atherosclerosis seldom gives any symptoms until advanced or when an occasional complication occurs.

Discussion

Atherosclerosis may be found at all ages but seems to increase in most people with increasing age. In the female during the child-bearing period, it is of less frequent occurrence than among men of the same age group, but in later decades it becomes as prevalent as in men.

Chickens in the egg-laying period are quite immune from atherosclerosis. In ages beyond the egg-laying period, injections of estrogen can prevent the formation of plaques which otherwise are readily produced. Recently, Major William F. Enos[1] reported the autopsy findings on 300 American soldiers killed in action in Korea. He found among these men, whose average age was 22.1, 77.3% showed some evidence of coronary disease. Twenty of these men had more than 40% closing of their coronaries. Two of them showed complete occlusion of a coronary artery. He indicated that the heavier the soldier, the more prevalent this condition. He also reported that in 20 Japanese males from the Tokyo medical office between the ages of 14 and 28, 71% showed a similar condition. He also noted that among 1480 post-mortem examinations among Japanese civilians, 14 had died of coronary disease. In Hawaii, of 3556 death reports of which 57% were Orientals, of those with cardiovascular disease, 50.6% were Orientals[2]. The Caucasians, who constituted 23% of the deaths, had 27.4% of the deaths from such conditions.

During 1953 at The Queen's Hospital, 75 Caucasians were admitted for coronary artery lesions to only 19 Orientals, yet a total of 5254 Orientals to 4565 Caucasians were hospitalized[3]. Even such gross figures not corrected for age suggest strongly that atherosclerosis is more prevalent in Caucasians than in Orientals.

In World War II, the armed forces reported 40,000 necropsies. Many showed coronary disease. Of these, three-fourths had died suddenly. Dr. Isadore Snapper, who had worked in China, reported that the starving Chinese (and he said that, as a Caucasian doctor, that was the only kind of Chinese he treated) at death showed no or very little atherosclerosis.[1] He wondered if the high milk, high fat diet of the Americans had something to do with the amount of arterial damage so frequently noted in the United States.

At the recent meeting of the American College of Physicians in Chicago, various phases of the atherosclerotic problem were discussed. It was evident that there is still a great difference of opinion as to exact causes. Some of the factors mentioned were that there is a definite thinning of the arterial intima of the female as compared with the male. Also it was repeatedly stated that the estrogens gave a certain degree of immunity, and that heredity was possibly a factor. In those who have advanced atherosclerosis, the alpha lipoprotein was found in much lower percentage than in normals. Controls for this are rather difficult to obtain since it is difficult to make a clinical diagnosis of no sclerosis (normal). Several speakers noted that there is not enough evidence at present for advocating the presently recommended dietary regimes either as preventives or as cures. The evidence is still insufficient to warrant recommending any specific diets, according to them. Certain chemicals were advocated to reduce this condition by lowering blood cholesterol. The most recent of these were beta-sitosterol from wood pulp and gamma-sitosterol with stigmosterol from soy sources. These taken by mouth prevented the absorption of cholesterol from the intestine and caused a lowering of the serum cholesterol. It was also ventured that if the blood cholesterol is over 300, the person has taken at least 40% of his calories as fat. In the old Japanese diet 80% of the calories came from salt-free rice. However, the cholesterol level or the change of the phospholipid ratio has not been proven as a cause of arterial damage. Another recent observation was that cortisone raises the alpha lipoprotein and that such blood is less atherogenic than one with a low alpha lipoprotein. It was demonstrated in a study of the pathology of this condition that the severest damage and the earliest occurs at points of stress in the vessel. Still another report suggested that the atheromatous lesion was due to a marked phagocytosis of lipids by certain cells occurring at points of stress in the artery. Hence, it might be a healing process. Such deposit of lipids by these cells could produce the plaques.

The figures presented from our local study help to confirm some of these observations, especially as to sex, age, and possible diet relationships. The findings also suggest, in comparing the Orientals and Caucasians under 45 as compared with those over 45, that the younger members of the two races have more nearly the same percentage of atherosclerosis than the older ones. That observation may indicate that as the Oriental is adopting the Caucasian diet with its richer intake of fat, cholesterol and calories, he tends to develop the same degree of atherosclerosis. The older Oriental tends to have much less of this

[1] Report given at the Annual Meeting of ACP in Chicago, April, 1954, to be published during the year by the various authors.

[2] Board of Health Statistical Dept.

[3] The Queen's Hospital Record Dept.

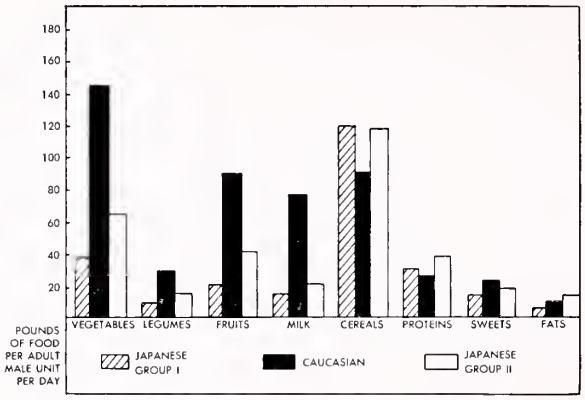


FIG. 5—Comparisons of Diets.

condition, possibly due to a greater difference in his diet. Twenty years ago a careful diet study was made. The difference of the Oriental versus the Caucasian diet is indicated in Figure 5.

Perhaps 20 years from now when all the people on these islands are eating approximately the same food (merely crystal ball gazing) a recheck will show no racial difference in atherosclerosis.

Conclusion

A study of 1250 autopsies in Honolulu was made. The findings indicated that atherosclerosis is more common in the male than in the female, although the female after the child-bearing period approached the male percentage.

That age seems a definite factor in the development of this condition.

That there seems to be a difference between the Caucasian and the Oriental but that this difference seems to be decreasing with the increasing number of Orientals who are eating the Caucasian diet. Another study twenty years from now may help to answer this question.

1133 Punchbowl St. (The Medical Group.)

ENDOCARDIAL FIBROELASTOSIS IN INFANCY

W. HAROLD CIVIN, M.D.* AND ALVIN V. MAJOSKA, M.D.,† Honolulu

ENDOCARDIAL fibrosis (sclerosis, fibroelastosis, or fetal endocarditis) was first reported by Kreysig (cited by Krstulovic[1]) in 1818.



DR. CIVIN

In Hawaii, recently, there came under observation two male children who were afflicted with this condition.

One of the children was 4 months old. His mother's pregnancy and labor were uneventful as far as could be determined. Four days before death, the patient developed a "common cold." The child was found dead in bed.

The other child was 2 years and 6 months old. His mother had a history of slight albuminuria during the last four months of the pregnancy. The mother's Kahn was negative during the pregnancy. The child was seven months premature. The boy was described as being in perfect health. The afternoon of the day of death, the patient received a diphtheria-pertussis-tetanus toxoid immunization. The child died suddenly a few hours later.

At necropsy, the four-months-old child showed the chief difficulty in the heart. This weighed 80 grams (normal for age, 27 grams) and was globular. The great vessels entered and left the heart in normal relationship. The ductus arteriosus was closed, as was the foramen ovale. The left ventricle was markedly dilated and hypertrophied and there was marked thickening of the endocardium, which appeared as a thick white membrane covering the superior two-thirds of the ventricular cavity. This was also seen, to a lesser extent, in the right ventricle.

Microscopic examination revealed extreme endocardial fibrosis with no inflammation. Thick bands of fibrous tissue extended deeply into the myocardium. Elastic stains revealed markedly increased elastic fiber formation.

The second child, at necropsy, presented a heart weighing 110 grams (normal, 58 grams). The right ventricle was dilated and hypertrophied. The left ventricle showed marked endocardial fibrosis with extension of the fibrosis into the myocardium (Fig. 1).

On microscopic examination, the thickened endocardium showed fibrosis with increased elastic fiber formation. Inflammation was absent.

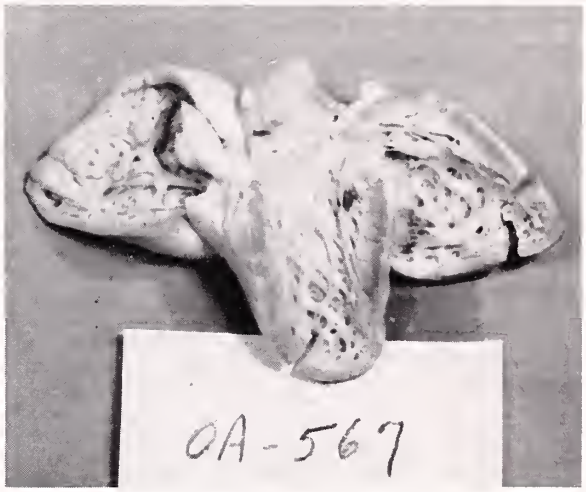


FIG. 1.—Photograph of heart showing marked endocardial fibrosis involving ventricles including the trabeculae carnae.

Discussion

Endocardial fibrosis or sclerosis (endocardial fibroelastosis, fetal endocarditis) with cardiac hypertrophy in the absence of major malformation of the heart had been reported only 41 times up to August, 1951.[1] We are acquainted with 4 previously unreported cases in the Territory, including the 2 reported above. Furthermore, the condition is not as rare as may seem, because it, or a similar process, is a major cause for rejection of applicants to the army in East Africa.[2] Davies, an acute observer, feels it is associated with a nutritional disease occuring here and elsewhere and known as kwashiorkor or "malignant malnutrition." This has been recently reviewed in the J.A.M.A.[3] Nevertheless, the condition appears to have escaped general recognition.

Clinically, the outstanding feature is difficulty in breathing. Cyanosis may be present. Other manifestations may include anorexia, irritability,

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† Coroner's Physician, City and County of Honolulu.

[1] Dordeck, J. R.: Diffuse Endocardial Fibrosis and Cardiac Hypertrophy in Infancy, Am. J. Clin. Path. 21:743 (Aug.) 1951.

[2] Davies, J. N. P.: Kwashiorkor (and discussion), Trans. Ninth Conf. of Liver Injury, Josiah Macy Foundation, 1951, 151.

[3] Williams, C. W.: Kwashiorkor, J.A.M.A. 153:1280 (Dec. 5) 1953.

failure to gain weight, convulsions, etc.; or there may be no symptoms at all and this is an added cause of "sudden death."

The cause of the condition is in doubt. In the early literature these cases were all considered as "fetal endocarditis," if in youngsters. More recently, mounting evidence has been noted in support of the condition's being of congenital origin. Other etiologies suggested are metabolic disorder, circulatory deficiency and nutritional deficiency.

Proponents of the infectious theory hold that since this condition is reportedly found chiefly in infants, the infection is intrauterine. This is based chiefly on the absence of signs of infection elsewhere in the child and on the occasional findings of foci of inflammatory cells of the chronic type in the heart. In 12 of 20 cases where pregnancy history of the mother was available, no complication was noted. In the rest, minor surgical procedures or acute upper respiratory infections were commented on during pregnancy.

Opponents of the infectious theory state that there is insufficient evidence for infection. The presence of the disease in siblings, they contend, indicates the possibility of a germ plasm defect. Gross questioned why so destructive a lesion (producing a large amount of fibrosis) should remain so localized (to the heart) if infectious in nature. Associated, generally accepted, congenital anomalies in other parts of the body at times have led some observers to favor the congenital origin of the defect. The failure to find historical, clinical, or pathological evidence of inflammation in most cases has led to postulates of metabolic, circulatory, and nutritional (as well as congenital) abnormalities' being etiologic factors. The findings in East Africans are advanced as a point in favor of a nutritional deficiency. However, the identity of the East African cases and those in infancy has not been established to everyone's satisfaction. Johnson[4] recently has felt that endocardial fibroelastosis always develops in hearts having associated malformations which could produce endocardial anoxia. The usual malformations involved, he feels, are anomalies of the coronary arteries, premature closure of the foramen ovale, and valvular atresia. In his causes of anoxia he includes two cases of idiopathic hypertrophy. There are a number of authorities who feel that the hypertrophy may be secondary to the fibroelastosis. Johnson does feel that other factors may be also involved. At present it would seem judicious to say that the cause of endocardial fibroelastosis is unknown, but is probably not inflammatory.

Edwards[5] has classified the condition under discussion into a contracted type (constrictive endocardial sclerosis) and a dilated type, depending on the condition of the left ventricle. The different factors mediating the development of the two types of lesions is unknown.

It has been suggested that the disturbance of function in the constrictive type is due to prevention of adequate diastolic expansion of the left ventricle. In the dilated type it is hypothecated that the thickened endocardium seals the left ventricular ostia of the thebesian veins and so alters the circulatory dynamics. Furthermore, it has been suggested that the fibrosis mechanically hinders both full dilatation and full contraction.

The cases described in this paper were both of the dilated type. There was no history of maternal infection during pregnancy. The prenatal history of albuminuria in the mother of the two and one-half-year-old child is hardly sufficient evidence of infection in the absence of corroborative evidence. Again, albuminuria *per se* is not indicative of toxemia except perhaps in the minds of some strict theorists.

The presence of a "cold" in the four-months-old child might indicate an infectious process. However, the extreme fibrosis seen is certainly of more than the four days' duration noted in the clinical process. Furthermore, no inflammatory cells (excluding fibrocytes) were present in the heart.

Nutritional and metabolic, as well as circulatory deficiencies could not be ascertained. Concomitant congenital defects were not present in the children.

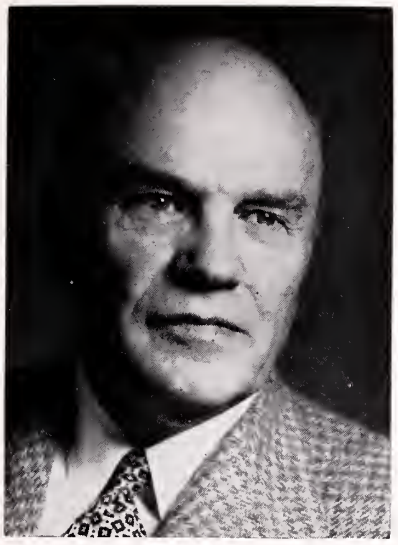
It should be noted that both hearts were hypertrophied. Certainly, a number of cases of so-called congenital idiopathic cardiac hypertrophy are of this type. It would appear, however, that not all fall in this category. One of us has recently seen two siblings with cardiac hypertrophy without endocardial sclerosis and with no other etiologic factor demonstrable.

Summary

Endocardial fibroelastosis is probably not as rare as has been hitherto believed. Its genesis is unknown. It may be a cause of sudden death and of otherwise unexplained cardiac hypertrophy in children.

[4] Johnson, F. R.: Anoxia as a Cause of Endocardial Fibroelastosis in Infancy, A.M.A. Arch. Path. 54:237 (Sept.) 1952.

[5] Edwards, J. E., Primary Endocardial Sclerosis, 420: in Goulg. Path. of the Heart, Charles C. Thomas, Springfield, Ill., 1953.



NILS P. LARSEN, M.D.

The President's Page

From an insurance company, I received the address of the retiring A.M.A. President, Dr. Edward J. McCormick, given to the House of Delegates at their annual meeting. The insurance executive wrote, "We were particularly interested in Dr. McCormick's discussion of average fee lists . . . it is our hope that your association may give consideration to this type of program."

In the attached pamphlet Dr. McCormick stated in part: "An additional positive step by the medical profession can be taken that would benefit not only the policyholders but the various underwriters as well. The profession should consider the creation of average fee lists or fee schedules that would prevail . . . on a regional basis for the vast majority of cases. If the profession could evolve such a program it would serve two main purposes . . . establish appropriate values for professional services that would be known to the public . . . insurance underwriters would know what schedules of benefits to offer in various areas . . . Another accomplishment of this proposed program would be to eliminate a large proportion of the complaints of patients with respect to fees. . . .

"After such a program is arranged by doctors themselves . . . those of our members who fail to cooperate, who overcharge, and who add to their bills over and above the reasonable fees determined, should be called before the grievance committees of their local societies to show cause why they should not be suspended or expelled.

"It seems to me that if such a proposal . . . can be approved . . . the patient will be served and medicine safeguarded. Scandals that have been publicized would be prevented . . . Voluntary insurance becomes a sham unless we take definite action to make the protection realistic. . . .

"The time has passed when the medical profession can predicate a fee on the basis of ability to pay. The well-to-do man or woman is resentful of this ancient practice . . . the days have passed when physicians can compute their fees on the basis of a patient's salary."

The president of the A.M.A. wrote this after visiting hundreds of communities and talking to thousands of people. He knows whereof he speaks.

The abuses that have given the profession a black eye come from a very few of our profession. This is verified by the HMSA records. By taking the realistic attitude suggested, we can prove to the community that our number one thought is service, and that the real satisfaction we get from our work is doing a good job and being helpful to the community in which we live. If we all support the new plan when it is finally completed it will do more than anything else to keep our profession in the true American tradition of a free enterprise. If we all work together we can deliver "more and better care" for less money than anyone else. And our whole profession can participate.

Nils P. Larsen

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[EDITORIALS]

New Health Executives

The Hawaii Cancer Society and the Hawaii Heart Association acquired new Executive Directors—the second one for Cancer, the first for Heart—in November and October respectively.

The Heart Association, which recently conducted its first public appeal for funds, announced the appointment of Mrs. Sabra Sadler as its first full-time Executive Secretary. Mrs. Sadler, Virginia-born, and educated at the College of William and Mary and the University of Virginia after her graduation in nursing at the Medical College of Virginia, has been interested in heart disease ever since her nursing school days. She has been consultant nurse on the Virginia State Rheumatic Fever Program since 1941. She is the author of *Rheumatic Fever—Nursing Care in Pictures,* the first book on this subject for parents, as well as several articles on heart disease.

The Hawaii Cancer Society has been fortunate in being able to replace its original Executive Director, Ted Rhea, who died last July, with a physician specially qualified in cancer control work: Dr. Walter B. Quisenberry. Dr. Quisenberry, a graduate of the College of Medical Evangelists in 1941, also holds a degree of M.P.H. (Johns Hopkins, 1945) and is a diplomate of the American Board of Preventive Medicine and Public Health. A native of Missouri, he has been with the Territorial Department of Health since 1947, when he became Chief of its Bureau of Venereal Disease and Cancer Control. Since 1951, he has been Director of its Division of Preventive Medicine. In 1953 Dr. Quisenberry was invited by the British Medical Association to participate in a panel discussion on Cancer and the Community at its annual meeting in Cardiff, Wales. This last summer he delivered the James Ewing Memorial Lecture on cancer before the New York Academy of Medicine. Dr. Quisenberry has been a member of the Board of Directors of the Cancer Society continuously since its reactivation in 1948, and has also served as a member of its board of cytologic diagnosticians.

Mrs. Sadler and Dr. Quisenberry are welcomed as distinguished additions to Honolulu's able group of voluntary health agency executives. Their offices will be in the communally operated Lunalilo Health Building, which also houses the Tuberculosis Association, the Oahu Health Council, the Polio Foundation and the National Society for Crippled Children.

The Decline of the House Call[1]

Once the standard symbol of the medical practitioner, the little black bag seems headed for a museum. The house call is coming to account for less and less of the doctor's practice. The horse and buggy doctor would have included the maintenance of both the horse and buggy in his income tax deduction if they had income tax in those days. Making calls was a large part of his practice.

Now that transportation has become swifter, the doctor's need for it has become less. Some physicians practically never make house calls. Others do so with great reluctance and impose on the patient such discouraging obstacles as higher fees and tardy arrivals.

The reasons for this reluctance to make house calls are that the doctor is too busy, that equipment in the office is better, or that the patient is not as sick as he thinks. This is quite in line with the trend of the times. Probably nothing that can be said or done now will reverse the trend. How-

[1] Editorial, J. Med. Soc. of New Jersey 51:335 (Aug.) 1954.

ever before the house call becomes completely extinct we would like to utter this requiem.

There is nothing quite as challenging as a closed door. The doctor who has never waited for the door to open has lost out on one of life's interesting experiences. With today's modern diagnostic equipment it is much easier than it used to be to make a diagnosis. But in the home, the doctor must make a diagnosis with only the simple equipment he can carry in the bag plus his eyes, his ears, his fingers, his medical training and, one hopes, his God-given common sense. If he can do that, he is really playing in medicine's major league!

A patient sends for a doctor only when he considers himself in trouble. The doctor who responds is viewed as a friend in deed. Many harsh things have been said about medical practitioners during the last two decades. But no one ever says them about the doctor who is willing to reply to a cry for help by making a call to the home. Such a call may be time taking, economically profitless and subject to certain technical and scientific deficiencies. It is a cheerful symbol of service to people in trouble—a service which is the glory and the touchstone of our creed.

Some Salmonellological *reading*[1]

One of *The Lancet's* imitable (but only by one another) and anonymous Peripatetic Correspondents (perhaps a resident of *chester, norwich,* or *horsham*) concluded his column in the issue of last June 26 with the following commentary on the nomenclature of the Salmonellae, those ubiquitous little pathogens dealt with in a more serious vein in this issue of the JOURNAL by Dr. Levine.[2]

Reactions of a Morbid Anatomist to Making the Acquaintance of the Kauffmann-White Scheme

I'm sure when White and Kauffmann wrote their Salmonella scheme
They little thought that they'd composed the poetaster's dream.
Who minds anaerogenesis or antigenic loss?
There's consolation in the sound of names like *hvittingfoss.*

While *morehead* dreams of *poona,* with *havana* and *champaign,*
I drive *uphill* from *nottingham* with *thompson* in the rain.
We'll stop and have a *worthington* in *shipley* on the way
We'd have made it a *manhattan* had it been a *desendai.*

My *mission* will require me to fly out to *kaapstad* soon
By *napoli* and *cairo* through an *aequatorial* noon.
mendoza, old *hidalgo,* will put on his *panama*
And join me in *nairobi*—it isn't very *pharr.*

Aunts *adelaide* and *berta* will enjoy the *eastbourne* sun
An *infant* is quite happy with *banana, ball* and bun.
Let *hindmarsh* take *madelia* in his *austin* to Dunoon,
But *give* me *loma linda* and a *pensacola* moon!

Before the Salmonellae lose their eponymic names
(*way cross* the wide *missouri* and to *georgia* away!)
Ere Arab numerals replace the Roman ones, who blames
A *london* salmonellogist who *sanga* little lay?

---

[1] In England Now: A Running Commentary by Peripatetic Correspondents, Lancet 266:1344 (June 26) 1954.

[2] Levine, M.: Salmonella and Salmonella Infections. I: Identification of Salmonella Types and Significance of Salmonella Typing, HAWAII MED. J. 14:113 (Nov.-Dec.) 1954.

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This is What's New!

In Manchester, England, Forrester, Jefferson and Naunton report the virtual elimination of **retrolental fibroplasia** by avoiding the use of high concentration of oxygen in premature infants. They found that decreased use of oxygen did not increase the mortality rate in the premature infants. In the past seven years, in two premature nursery units they discovered 83 cases of retrolental fibroplasia with 21 of the infants being blind. Since restricting the use of high oxygen concentration three years ago, they have had no infants with blindness due to retrolental fibroplasia. [*The Lancet,* CCXVII:258 (August 7) 1954.]

Why **blood vessels dilate** distal to **stenosing vascular lesions** is explained by E. Holman. The intriguing fact that the aorta in congenital coarctation is dilated distal to the site of coarctation is apparently due to post stenotic drop in pressure with conversion of high kinetic energy into high potential energy with increased lateral pressure against the vessel wall. Associated with this, there are eddy currents of alternating high and low pressures causing structural stresses to the distal vessel wall. [*The Journal of Thoracic Surgery,* 28:109 (August) 1954.]

Without a broad spectrum antibiotic to call their own, E. R. Squibb & Sons have been at somewhat of a disadvantage. With their release of **mycostatin** (Squibb Nystatin), an antifungal antibiotic obtained from Streptomyces noursei, this disadvantage may be transient. One 500,000 unit tablet taken t.i.d. for a few days appears to be the most specific treatment for **intestinal moniliasis** following the use of the broad spectrum antibiotics. [Squibb Project Brief.]

Four British physicians report that the **A,B,O blood groups** correlate with benign and malignant **lesions of the intestinal tract.** Carcinoma of the stomach is significantly more frequent in patients with group A while benign gastric and duodenal ulcers are more frequent in patients with group O blood. There is no correlation with cancers of the colon, bronchus or breast. [Aird, et al., *British Medical Journal,* 4883:315 (August 7) 1954.]

In the same issue of the *British Medical Journal,* other workers report that **toxemia of pregnancy** is more prevalent in women with **group O** and that carcinoma of the lung does not correlate with the A,B,O blood groups. All of this bears out our belief that eventually the important facts in medicine will be unearthed. Here it was only last December that a Swede discovered that women with inverted nipples tend to have migraine, at least in Sweden.

There may be hope for patients suffering from **plutonium poisoning.** This heavy radio-isotope which is fuel for the atomic energy plants is concentrated in the victim's bones. There it continues to irradiate the body for the remainder of the patient's life with bone necrosis, marrow damage and osteogenic sarcoma as possible late complications. **EDTA** (ethylene diamine-tetra-acetic acid), which has been used with success in lead poisoning, accelerated the excretion of Pu^{239} in two atomic workers who were accidentally poisoned. [Foreman, et al., *A.M.A. Archives of Industrial Hygiene,* 10:226 (September) 1954.]

Add one more use for adrenocortical extract. **ACE** causes crayfish to assume a redder hue by depressing the darker pigment of their shells. [Goldman and Wells, *Science,* 120:350 (August 27) 1954.]

Reports on **systemic lupus erythematosus syndrome** as a result of **Apresoline** therapy for hypertension continue to appear. One patient treated for nine months developed the full clinical picture of L.E. with L.E. cells demonstrated in the peripheral blood. The entire picture cleared one month after cessation of therapy. [Shackman, et al., *J.A.M.A.,* 155:1491 (August 21) 1954.]

FRED I. GILBERT, JR., M.D.

Woman's Auxiliary

The Woman's Auxiliary to the Hawaii Medical Association contributed an interesting calendar of social events during the Sixth Congress of the Pan-Pacific Surgical Association held here in October. Mrs. Ralph B. Cloward, President, acted as coordinating chairman, assisted by members of the Auxiliary.

A welcoming morning brunch and fashion show held at Queen's Surf was a high light in the program for Surgical Congress wives. The theme was Fashions Internationale and featured a unique presentation of authentic costumes and dances of the various racial groups of Hawaii and their adaptations in modern fashions. Represented were the Tahitian, Chinese, Filipino, Japanese, East Indian, and Hawaiian peoples. This event was prepared by the staff of Queen's Surf, together with Watumull's Stores, who provided costumes, models, and original fashions. Mrs. Elaine North of United Airlines served as fashion commentator and program coordinator. A few of the visiting guests present were Mrs. I. S. Ravdin, Philadelphia, Pennsylvania; Mrs. Daniel Morton, Los Angeles, California; Mrs. Stuart Harrington and Mrs. L. M. Randall, Rochester, Minnesota. Auxiliary chairman for the brunch was Mrs. F. J. Pinkerton.

The evening before, a reception and cocktail party at Tripler Army Hospital Officers' Club opened the social program. An invitation was extended to the doctors and their wives to tour Tripler Army Hospital in the afternoon. Mrs. C. M. Burgess was chairman of this event, and Mrs. Thomas J. Hartford was co-chairman. Mrs. Thomas W. Cowan and Mrs. Frederick L. Giles were in charge of the decorations and floral arrangements for the occasion. Doctors' wives served as hostesses.

One of the most important projects of the Auxiliary was the hostess information desk which was maintained at the Royal Hawaiian Hotel to accommodate visiting doctors and their wives. Mrs. Douglas Bell was chairman of the project; Mrs. Garton Wall was co-chairman. Members of the Auxiliary took charge of the desk during the seven-day Congress from 8:00 A.M. to 4:00 P.M. Another contribution of this committee was to work with the Hawaii Visitors Bureau assembling tourist information pamphlets which were presented to members of the Congress along with their official Pan-Pacific Program.

Four members of the Auxiliary were called upon to assist Dr. Nils P. Larsen, author and director of the pageant, *Birth and Growth of Surgery in the Pacific*. The production was held at Queen's Hospital to dedicate the new surgical wing as part of the official program of the Surgical Congress. Mrs. P. Howard Liljestrand was in charge of the musical sequences. Mrs. Robert Johnston and Mrs. Robert Katsuki obtained the assistance of staff members and their children. The children marched on stage carrying flags of fifty-seven nations. Mrs. Kyuro Okazaki assisted by obtaining the authentic costumes of the year 1650 which were used in the scene portraying the Three Japanese Doctors. Following the pageant, Governor and Mrs. Samuel Wilder King received the delegates and their wives at a reception in their honor held at Washington Place. Mrs. Francis J. Halford was coordinating chairman from the Woman's Auxiliary.

Dr. I. S. Ravdin of Philadelphia, president of the association, and Mrs. Ravdin were hosts at the traditional president's reception held at Queen's Surf. This was followed by a luau which was the closing function on the program. Mrs. Thomas Richert and Mrs. Robert Millard were chairmen of the committee on decorations, while Mrs. Hon Chong Chang was chairman of the telephone committee. The decorations were carried out under the direction of Mrs. Caroline E. Peterson, who, with a large number of Auxiliary members, devoted two days to the task of decorating the luau tent and making floral arrangements for the tables. There were generous contributions of flowers and plants from Auxiliary members and their friends. A vote of thanks should be extended to the Hawaii and Maui Auxiliaries for sending flowers; to Mrs. J. M. Kuhns of Kauai who contributed two hundred beautiful crown flower leis, and who also helped with the decorating; and to Mr. Colin Potter of Foster Gardens who contributed many lovely seed plants. The tables were beautiful with anthurium, orchid, and bird of paradise centerpieces, as well as Hawaiian puolos and crown flower leis. The program was an exceptional presentation of historical Hawaiian lore and dances, and, together with the Hawaiian feast, provided a fitting climax and gesture of Aloha to the Pan-Pacific delegates and their families.

MRS. L. L. BUZAID

Perhaps It's Your Nerves

The Patient's Motivation as a Medical Tool

ROBERT A. KIMMICH, M.D.

Much attention has been paid in recent years to the importance of the relationship between patient and physician. This relationship is of basic importance since it is the keystone of proper carrying out of the treatment plan.

The patient comes with certain preconceived ideas about his illness, the doctor, the treatment process and his own prognosis. These are a mixture of phantasy, reality, anxiety and optimism. He may be correct about his diagnosis but completely wrong and fearful about the treatment. He often expects or hopes for a "miracle cure." Current popular writing or simply his own reaction to fear of his illness may have a major part in producing such unreal hopes. At a deeper level is the magical and primitive belief in the omnipotence of the physician.

The unconscious over-valuation of the doctor is not necessarily a handicap; in fact it is one of the effective factors in the therapeutic course of events. The patient comes because he wants help and must consider the doctor strong and reliable enough to give the needed help. That is, the doctor must be more "powerful" than the patient.

Primary motivation for seeking the doctor is usually based on pain and fears relating to discomfort—that is, symptoms. The patient seeks the cessation of discomfort and return to the emotional and physiological balance experienced as health. Our culture has taught him that there are things to be done that can help him, especially in the hands of a special person with special skills.

This very strong motivation for help also brings with it, however, a fear of the unknown treatment. Also, most people are uneasy with their own helplessness and are reluctant to expose their infirmities. The conviction that treatment may bring more pain than the disease often lurks in the background as well. We can see, therefore, that even as the patient seeks our help he is in conflict about getting help or avoiding it. One part of our task in the early phases of contact with the new patient is to help him clarify and increase his motivation to seek help and decrease the tendency to avoid it.

It becomes clear that a patient will be willing to accept the treatment and continue with it over an indefinite period of time if his attitudes toward the doctor remain largely positive. He will be able to wait, he can endure necessary pain and can take a more realistic view of his illness under these conditions.

In producing such an attitude we, consciously or unconsciously, behave toward the patient in such a way that he will be rewarded psychologically for useful attitudes. *How we behave* is as important as *what we say* for the patent is in some ways quite infantile in his needs when he feels helpless against his illness. The rewards he receives are many in form. They may be anything from verbal approval of his cooperation to actual cure of his disease. A smile, a question or even an appropriate silence may be rewarding. Preparing him for a painful manipulation or understanding his fears of treatment may show him our interest in him as a person and that we do not regard him simply as a helpless "bag of symptoms." He will feel he also participates in treatment.

The physician's warm, sympathetic attitude and his assured, professional manner tend to reduce excessive anxiety and also such consistent positive behavior will tend to help the patient imitate or "identify" with the doctor. This is a great and important source of strength to patients. They are quick to pick up anxiety, evasiveness, and irritability on the part of the doctor and apply it to themselves or turn it back upon the physician himself.

Just as a child gains strength from imitation of the important parent-figures in his life, so do the patients gain hope and strength from the physician toward whom they have trust and positive feelings.

A patient will be able to take and utilize advice, therapeutic manipulation and even kindly rebuke only if he has first built a strong positive feeling for his doctor. Thus, before we undertake deeper and more difficult parts of the treatment regime we must first evaluate the patient's readiness and ability to cooperate in carrying it through. (This would obviously not hold in the case of an emergency situation where immediate drastic intervention is clearly indicated.)

Thus we submit that the helping *attitudes* of the physician are often of a magnitude of importance equal to or greater than the actual specific surgical or pharmacologic procedures prescribed. We must remind ourselves that even in the case of an "entirely physical" disease such as a broken bone, the patient also inevitably reacts to it with certain anxieties, hopes and changes in his behavior.

Clarification of his illness, erasing unrealistic fears and expectancies, outlining a fairly understandable regime, giving some idea as to course and prognosis, all help in keeping him cooperative and justifiably reward his confidence in the doctor. He will be ready to continue his treatment beyond the two most difficult periods, namely, the phase where therapy is most fearful to him and the phase where his symptoms have been so alleviated that he sees no further need for treatment.

We might restate our thesis by saying that no matter how great the knowledge and skill of the physician, he cannot effectively treat if the patient does not cooperate or leaves in the middle of treatment. Much of the responsibility for the long-term course of events lies with the doctor himself and his cognizance of the emotional as well as physical needs of his sick patient. In this way, kindly rewarding and strengthening of the patient's positive motivation becomes a significant therapeutic tool.

The Honolulu County Medical Library

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Recent Acquisitions

Allergy

Vaughn, W. T. *Primer of allergy.* 4th ed. rev. c1954. (gift of publisher).

Cancer

Greenstein, J. P., ed. *Advances in cancer research.* c1954.

Cardiology

Kaplan, H. S. *Congenital heart disease.* c1954. (gift of publisher).

Circulatory System

Green, H. D., ed. *Shock and circulatory homeostasis.* Trans. . . . 3rd Conf., Sept. 14-16, 1953. c1954. (gift of Josiah Macy, Jr., Foundation).

Digestive System

Hoffbauer, F. W., ed. *Liver injury.* Trans. . . . 12th Conf., Sept. 21-23, 1953. c1954. (gift of Josiah Macy, Jr., Foundation).

Jones, F. A., ed. *Modern trends in gastroenterology.* 1952. (from Board of Medical Examiners).

Endocrinology

Pincus, G., ed. *Recent progress in hormone research.* v.19. c1954.

First Aid

Young, C. B. *First aid and resuscitation.* c1954. (gift of publisher).

Geriatrics

Shock, N. W., ed. *Problems of aging.* Trans. . . . 15th Conf., Jan. 20-22, 1953. c1954. (gift of Josiah Macy, Jr., Foundation).

Gynecology and Obstetrics

Atlee, H. P. *Chronic iliac pain in women.* c1954. (gift of publisher).

Page, E. W. *The hypertensive disorders of pregnancy.* c1953. (gift of publisher).

Legal Medicine

Gonzales, T. A. *Legal medicine, pathology and toxicology.* 2nd ed. c1954. (gift of publisher).

Gradwohl, R. B. H., ed. *Legal medicine.* c1954. (gift of publisher).

Medicine

Benivieni, A. *The hidden causes of disease.* c1954. (gift of publisher).

Reifenstein, E. C., Jr., ed. *Metabolic interrelations.* Trans. . . . 5th Conf., Jan. 5/6, 1953. c1954. (gift of Josiah Macy, Jr., Foundation).

Neurology and Psychiatry

Moses, P. J. *The voice of neurosis.* c1954. (gift of publisher).

Netter, F. H. *The Ciba collection of medical illustrations. v.1. Nervous System.* c1953. (from Board of Medical Examiners).

Sonneman, U. *Existence and therapy.* c1954. (gift of publisher).

Spiegel, E. A. *Progress in neurology and psychiatry.* c1954. (from Board of Medical Examiners).

Wolberg, L. R. *The technique of psychotherapy.* c1954. (gift of publisher).

Nursing

Cardew, E. C. *Study guide for clinical nursing.* c1953. (from Nurses' Association).

Miller, N. F. *Gynecology and gynecologic nursing.* 3rd ed. c1954. (from Nurses' Association).

Roberts, Mary. *American nursing history and interpretation.* c1954. (from Nurses' Association).

Otolaryngology

DeWeese, D. D. *Dizziness.* c1954. (gift of publisher).

Orthopedics

Hollander, J. L., ed. *Comroe's arthritis and allied conditions.* 5th ed. c1953. (gift of publisher).

Howorth, M. B., *A textbook of orthopedics.* c1952.

Steindler, A. *Post-graduate lectures on orthopedic diagnosis and indications.* c1954. (from Board of Medical Examiners).

Parasitology

Kudo, R. R. *Protozoology.* 4th ed. c1954. (gift of publisher).

Pathology

Darlington, C. G. *Applied pathology.* 2nd ed. rev. c1954. (gift of publisher).

Pediatrics

Bakwin, H. *Clinical management of behavior problems in children.* c1953. (gift of publisher).

Livingston, S. *Diagnosis and treatment of convulsive disorders in children.* c1954. (gift of publisher).

Nelson, W. *Textbook of pediatrics.* 6th ed. c1954. (gift of publisher).

Pickles, M. M. *Haemolytic disease of the newborn.* c1949. (gift of publisher).

Senn, M. J. E., ed. *Problems of infancy and childhood.* Trans. . . . 7th Conf., March 23 and 24, 1953. c1954. (gift of Josiah Macy, Jr. Foundation).

Pharmacology

A. M. A. Council on Pharmacology and Chemotherapy. *New and non-official remedies.* c1953. (from Board of Medical Examiners).

Respiratory System

Reimann, H. A. *Pneumonia.* c1954. (gift of publisher).

Roentgenology

De Lorimier, A. A. *Clinical roentgenology.* (Head, neck and spinal column). v.3. c 1954. (gift of publisher).

Tropical Medicine

Mackie, T. T. *A manual of tropical medicine.* 2nd ed. c1954. (gift of publisher).

Miscellaneous

Burch, G. E. *Of publishing scientific papers.* c1954. (gift of publisher).

Garland, J., ed. *The physician and his practice.* c1954. (gift of publisher).

Kant, Fritz. *The treatment of the alcoholic.* c1954. (gift of publisher).

McFadden, C. J. *Medical ethics.* 3rd ed. c1953. (gift of Father Turck).

Quarterly cumulative index medicus. v.52. July-December, 1952. c1954.

The September, 1954 issue of the *Archives of Internal Medicine* contained an article on Histiocytic Medullary Reticulosis by Drs. Harold Civin, Henry C. Gotshalk and Kyuro Okazaki of Honolulu.

* * *

It is occasionally advisable to remind our borrowers of Library rules and regulations. These rules have been drawn up and approved by the Library Board and the Committee, and are reviewed regularly. The Board has decided that bound volumes should circulate for *three days only,* with no renewal, and if kept overdue, a fine of five cents a day for each issue in the volume is charged. Books and unbound journals may be borrowed for ten days, with renewal privileges. A fine of five cents a day is assessed if overdue.

It is embarrassing and time consuming to have to notify members of small fines they have neglected to pay. To facilitate matters for both the borrower and the Library, overdue charges should be paid at the time books and journals are returned.

Umi Makahiki I Hala*

Emergency Medical Services

The closing of Sacred Hearts Hospital, and the return of the building to the Church for its normal purpose of a schoolhouse, has left the entire staff of volunteers at Sacred Hearts Hospital without assignment. In order to provide emergency hospital facilities to care for a large number of casualties, the former Poliomyelitis Hospital (Shriners' Annex), has been rearranged, in accordance with the original plan, as an emergency casualty hospital. The hospital in Manoa Valley Japanese School has has also been continued . . .

H. L. Arnold, M.D.
Territorial Medical Director

Notes and News

The Post Graduate Course of the Honolulu Medical Society will be held in the Mabel Smyth Auditorium in Honolulu from January 8-14, 1945. Medical officers of the Army and Navy, as well as all members of the Hawaii Territorial Medical Association are cordially invited to attend. The registration fee will be ten dollars.

Members in Service

Capt. Lucius W. Johnson (MC) USN, medical officer of the 14th Naval District, has been promoted to the rank of Rear Admiral. Admiral Johnson is an honorary member of the Honolulu County Medical Society. His *Survey Report of Civilian Hospital Needs* was recently published in the Hawaii Medical Journal.

Comdr. R. J. Mansfield of the Medical Group received a Legion of Merit award for his work at Attu. Dr. Mansfield was in the original assault on Guadalcanal. He served in combat for many months, saw action at Attu, and then was at Tarawa where he received his decoration. After a service at Philadelphia Navy Yard, Dr. Mansfield has been transferred to surgery at Mare Island.

Lt. Col. Robert J. Hoagland's many friends will be interested to learn that he is commanding a field hospital somewhere in Belgium.

Personal

Dr. Colin C. McCorriston last September accepted a commission as Lieutenant (jg) in the Medical Corps of the United States Naval Reserve. He and Mrs. McCorriston announced the arrival on September 6 of their second son, William Colin McCorriston.

Dr. Ivar Larsen, physician for the Kohala Sugar Company, took a two weeks vacation last August. He was relieved by **Dr. T. A. Casey** of Honolulu. While on vacation Dr. Larsen took **Dr. Harry Arnold, Jr.** and **Dr. A. S. Hartwell** of Honolulu on a two-day trip over the Kohala Ditch Trail. Dr. Arnold, Jr. and Dr. Hartwell were on the Island of Hawaii for two weeks.

Dr. Douglas Bell of Honolulu spent two weeks on the Island of Hawaii in August during which time he managed some successful pheasant shooting.

Dr. W. N. Bergin, formerly physician at Laupahoehoe, has replaced **Dr. Thomas Keay** at Pepeekeo. Dr. Keay has retired and is living in California. **Dr. Fernandez** has replaced **Dr. Bergin** at Laupahoehoe and **Dr. Joseph Simon** is serving as assistant to Dr. Bergin.

* Ten years ago. From Volume 4, Number 2, November-December, 1944.

Book Reviews

Comroe's Arthritis and Allied Conditions.

Edited by Joseph Lee Hollander, A.B., M.D., F.A.C.P., Fifth Edition, 1103 pp., illustrated, Price $16.00, Lea & Febiger, 1953.

This text represents one of the best written volumes on the subject of arthritis. The author has not only covered the subject matter completely, but has presented it in an easily digestible manner. A summary of each important aspect of the individual disease entities is readily found by paging rapidly through the appropriate chapters.

The contents include all types of arthritis with concise and yet complete methods of treatment. Other diseases, such as trauma, painful shoulder, low back pain, etc. are also included.

I have enjoyed reviewing this volume so much, I have already purchased a copy.

JOHN M. FELIX, M.D.

Congenital Heart Disease.

By Henry S. Kaplan, M.D. and Saul Joel Robinson, M.D., 126 pp., illustrated, Price $12.50, McGraw-Hill Book Company, Inc., 1954.

An illustrated diagnostic approach intended primarily for the general practitioner. The description of relatively common congenital cardiac anomalies is a direct brief presentation. Clearly and concisely, there is an outline of practical diagnosis utilizing ordinarily available methods, namely clinical examination, radiography and electrocardiography.

The principles of differential diagnosis precede an atlas of electrocardiography and radiological features. Sketched drawings of cardiac chambers and great vessels are superimposed upon roentgenographs and correlated with the electrocardiographs to characterize each anomaly and its diagnosis. The method of diagnostic evaluation is impressive and conducive to practical use.

LOUIS L. BUZAID, M.D.

A Synthesis of Human Behavior.

By Joseph C. Solomon, M.D., 265 pp., Price $5.50, Grune & Stratton, Inc., 1954.

This book is written by a man who is obviously an experienced clinician and an orthodox Freudian. It is a very good book for anyone interested in the Freudian concepts. They are presented clearly in an interesting manner in terms of the successive periods of human development from infancy to maturity. It enables the person who is not psychoanalytically oriented to critically evaluate Freudian concepts, accepting some, rejecting others and questioning the rest. A good deal of thought, hard work and clinical experience is incorporated in a relatively small volume. In view of the wide repercussions of Freudian thinking in all spheres of medical practice this book is recommended as a readable, understandable presentation of psychoanalytic orientation in clinical practice.

J. ROBERT JACOBSON, M.D.

A Dynamic Psychopathology of Childhood.

By Lauretta Bender, M.D., 275 pp., Price $7.50, Charles C. Thomas, 1954.

This is actually a collection of articles written by a number of authors. The book starts off slowly with a chapter filled with the confusing language of the psychiatrist, complicated further by many grammatical errors. The remainder of the book is more interesting and should be of value to those dealing with children. Case histories are used freely and give the reader bases for judging the conclusions of the authors. Rather surprising to this reader was the condemnation of Lewis Carroll and the high praise of comic books.

M. L. HANLON, M.D.

Dizziness—An Evaluation and Classification.

By David Downs DeWeese, M.D., 80 pp., Price $2.75, Charles C. Thomas, 1954.

One could not ask for a more concise presentation of an otherwise complicated subject. Considering the amount of extant medical literature with its ever recurring iterations and its voluminous verbosity, one must salute a monograph on dizziness which is stripped to its bare essentials. The same treatise would mean different things to different people. The student may use it as a synoptic review before passing an examination. The general practitioner would quickly see how involved the subject is, while the specialist would be guided by a thoroughly systematic approach as outlined by a great authority in that particular field.

MAURICE GORDON, M.D.

The Digital Circulation.

By Milton Mendlowitz, M.D., 182 pp., illustrated, Price $6.75, Grune & Stratton, Inc., 1954.

If one were deeply interested in the complex mechanics of the caloric exchange in the fingertips and their relationship to arteriovenous flow, then this would probably be a worthwhile book. The presentation was highly technical and, to be truthful, a little over my head. As a clinician I got little out of it of practical value in the treatment of peripheral vascular disease.

C. M. BURGESS, M.D.

The Diagnosis and Treatment of Disorders in Children.

By Samuel Livingston, M.D., 314 pp., illustrated, Price $9.50, Charles C. Thomas, 1954.

This book provides for the physician who cares for children with convulsive disorders, a readable and clear review of the recent advances in this field. Therapeutic measures are discussed concisely. A brief expedition into the dark mystery of electroencephalograpy is very illuminating and profitable.

For the physician who must sit up at night, concerned over a convulsive child, this volume is a welcome companion.

RICHARD E. ANDO, M.D.

Clinical Roentgenology—Volume II.

By Alfred A. DeLorimier, M.D., Henry G. Moehring, M.D. and John R. Hannan, M.D., 464 pp., illustrated, Price $18.50, Charles C. Thomas, 1954.

This second volume of a proposed four volume work is designed to simplify the radiologic diagnosis of lesions of the skull, sinuses, teeth, neck and spine.

The volume is well arranged, particularly in the section covering the skull, the various normal and pathologic conditions being arranged separately to permit easy references. A minor point, but a disturbing one, is the lack of recent references in the literature cited at the end of each chapter. The latest reference found (a single one) was 1952; there were only 4 references from the year 1950 and 11 from 1949. The majority of the references to the literature are prior to 1940.

Although the descriptive matter is brief it is generally satisfactory for rapid reference. A list of synonyms at the beginning of each chapter is a helpful feature. The many roentgenograms (734 illustrations) are generally well chosen and are of excellent quality. All physicians whose interest lies in these fields should find this volume a valuable addition to their library.

RICHARD D. MOORE, M.D.

Clinical Management of Behavior Disorders in Children.

By Harry Bakwin, M.D. and Ruth Morris Bakwin, M.D., 495 pp., Price $10.00, W. B. Saunders Company, 1953.

The Bakwins here present a well-tailored synthesis of their experience and practical theory. Problems seen in your children and mine, in your practice and mine, are all discussed, stressing effective practical means for handling them. This is a good volume to have on a handy shelf.

J. G. HARRISON, M.D.

The Voice of Neurosis.

By Paul J. Moses, M.D., 131 pp., Price $4.00, Grune & Stratton, Inc., 1954.

This brief volume might as well have been entitled *The Neurosis of Voice,* since it deals entirely with the sound of the human voice. The author starts with the premise that vocal dynamics express psychodynamics. He then proceeds to devise a set of ingenious and sometimes definitive ways of measuring and recording the many acoustic dimensions of voice. His methodology in diffracting the vocal spectrum into hitherto unmeasured components is both interesting and thought-provoking.

Following a consideration of the ontogeny and phylogeny of the vocal organs, the author presents his views about the significance of voice in the varied functions of the person, both intrapersonal and interpersonal. This leads into a detailed analysis of the various characteristics of normal, neurotic, and psychotic vocalizations, and a plea for more widespread use of these new techniques in the diagnosis and treatment of functional disorders of the voice.

This book should be of more than passing interest to speech therapists, otolaryngologists, and diagnostically oriented psychologists. Others will find little of practical value in this treatise on vocal calligraphy.

WILLIAM H. STEVENS, M.D.

The Size and Growth of Tissue Cells.

By Joseph G. Hoffman, Ph.D., 128 pp., illustrated, Price $4.00, Charles C. Thomas, 1953.

This book presents the author's views upon the relationship of cell growth and size to malignant neoplastic change. It is stimulating and well written. It is of no use to the clinician and only of academic interest to the pathologist. Much space is given to a historical review of the subject, particularly that portion concerning methods of measuring cell components. It is difficult to understand why this material merited a hard binding unless the author did not wish the drudgery of composing a succinct summary of his views, such as articles in the medical press ordinarily require. As a review of the author's own opinions it is both stimulating and adequate. However, he omits mention of work done in this field by others working with similar aims, such as Timonen. It is unfortunate that American medical journals do not publish supplements along the lines of the Scandinavian publishers. This would be the ideal medium for a work of this type which is too long for the average journal and too short to merit the expense of binding.

G. N. STEMMERMANN, M.D.

First Aid and Resuscitation.

By Carl B. Young, Jr., M.P.H., 338 pp., illustrated, Price $8.50, Charles C. Thomas, 1954.

As the author states, this emergency manual is written not for those who have had training in medicine or its related fields, but rather for those who are engaged every day in practical street first aid. It is designed to supplement the American Red Cross First-aid manual.

The lay reader will find it interesting and easily digested. It covers some of the more common first-aid emergencies, thoroughly and in detail, from practical experiences.

The contents may prove of value to law enforcement agencies, to industry, to nurses and to hospital and ambulance attendants.

EDMUND C. K. LUM, M.D.

Neck Dissections.

By James Barrett Brown, M.D. and Frank McDowell, M.D., 163 pp., illustrated, Price $7.50, Charles C. Thomas, 1954.

Neck Dissection is one of the finest monologues on the subject. This interesting but somewhat neglected and obscure aspect of the surgical field is presented in a most concise but complete and organized fashion. References are made to 267 articles listed in its bibliography and all this is summarily embodied in 134 pages of good enamel paper with clear bold type. Numerous full page color surgical plates clarify the operative anatomy and procedure.

Neck Dissection should be read by all surgeons intending to do this type of work. It represents one of the few good sources of operative literature in the various techniques of neck dissection. For others, its reading should stimulate an excellent diffusion of interest and knowledge on a subject which has been relatively neglected and inadequately taught.

GEORGE H. NIP, M.D.

Clinical Measurement of Uterine Forces in Pregnancy and Labor.

By S. R. M. Reynolds, Ph.D., D.Sc., Jerome S. Harris, M.D. and Irwin H. Kaiser, M.D., Ph.D., 328 pp., illustrated, Price $9.50, Charles C. Thomas, 1954.

This book offers a good review of tokodynamometry in relationship to uterine activity. It gives the clinician an excellent comparison of forces exerted at different stages of normal and abnormal pregnancy and labor.

The significance of the psyche as well as the prodromal symptoms prior to labor are discussed. Of particular interest was the review of the effects oxytocics and analgesics have on uterine activity. This book is written for the obstetrician who likes to study and investigate the course of gestation and labor.

SYDNEY T. FUJITA, M.D.

Primer of Allergy.

By Warren T. Vaughan, M.D., Fourth Edition revised by J. Harvey Black, M.D., 191 pp., Price $4.25, C. V. Mosby Company, 1954.

This book is written primarily for laymen. It is written in such simple language that it will enable the allergic patient and his family to understand the intricacies of allergy. It should, therefore, foster a harmonious relationship between the patient and his family, and the physician.

The physician should also find this primer interesting and informative. It will help him in discussing allergy with the patient in simple words. It has a number of "instructions for patients" which can be used with or without modifications.

CLARENCE Y. SUGIHARA, M.D.

Cystic Fibrosis of the Pancreas in Infants and Children.

By Charles D. May, M.D., 93 pp., illustrated, Price $3.00, Charles C. Thomas, 1954.

In terse and very readable form the author tells just about all we now know about cystic fibrosis of the pancreas.

To me the two most interesting points made were: (1) The advisability—nay necessity—of avoiding dietary restrictions in these children, and (2) the fact that so many questions still remain to be answered.

And so—in the words of the author—back to the patients and the laboratory.

F. D. NANCE, M.D.

Textbook of Pediatrics.

Edited by Waldo E. Nelson, M.D., Sixth Edition, 1581 pp., illustrated, Price $15.00, W. B. Saunders Company, 1954.

Clear—Concise—Complete—A "must" for every pediatrician's or general practitioner's library.

W. B. HERTER, M.D.

Depression.

Edited by Paul H. Hoch, M.D. and Joseph Zubin, Ph.D., 277 pp., Price $5.50, Grune & Stratton, Inc., 1954.

This book is a symposium devoted to one of the important psychopathologies of today, depression. It does not aim at the conclusive finding of the cause of depression, of which we are still in the dark, but it aims at the dynamic understanding of the depressive state using a combined attack along the line of genetics, anthropology, physiology, endocrinology, biochemistry, biometrics, geriatrics, child psychiatry, and psychodynamically oriented psychiatry. It also includes hospital administration and its problem in the treatment of the depressed and a dissertation on the treatment itself. It is an interesting and absorbing book well worth reading.

DOROTHY S. NATSUI, M.D.

Pneumonia.

By Hobart A. Reimann, M.D., 236 pp., Price $5.75, Charles C. Thomas, 1954.

This is a compendium of nearly every type of pneumonia recognized in man, arranged on an etiologic basis. The author points out that contrary to common belief, despite the therapeutic triumphs made possible by the discovery of antibiotics, the incidence of the infectious pneumonias has not changed. The various types are discussed according to etiology, pathogenesis, pathology, symptomatology, prevention and treatment. The discussions are very brief and a bibliography is appended after each group. This book is heartily recommended to all practicing physicians, irrespective of specialty.

T. F. FUJIWARA, M.D.

Also Received

Arrest of Bleeding.

By Jacques Roskam, M.D., 71 pp., Price $2.75, Charles C. Thomas, 1954.

All about hemorrhage, by the Professor of Medicine at the University of Liège in Belgium.

Beyond the Germ Theory.

Edited by Iago Galdston, M.D., 182 pp., Price $4.00, New York Academy of Medicine, 1954.

Eleven thought-provoking essays on the production of disease by deprivation of various kinds.

Heart Disease and Industry.

By Meyer Texon, M.D., 324 pp., Price $7.50, Grune & Stratton, Inc., 1954.

A study of the medical and medico-legal aspects of heart disease in relation to industry, documented by 100 systematically analyzed cases.

(*Continued on Page 166*)

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Bureau of Medical Economics

In October 1953 I left for the mainland to observe two very successful collection agencies that are owned and operated by county medical societies, carrying the name, "Bureau of Medical Economics." During my visit, I asked their executive secretaries the following questions: Should doctors use a collection service? If so, when should an account be placed for collection? And why should the doctors use the Bureau of Medical Economics? I feel that these are questions many doctors may be asking themselves. They were explained to me in the following manner:

Should Doctors Use a Collection Service?

There is a definite place in professional practice for use of a collection service that meets doctors' special needs. People who pay for other services and commodities should also pay the reasonable cost of medical care. Most patients realize this and pay in a satisfactory manner, but every doctor has those who avoid payment if they can. These irresponsible patients should not receive "free" medical care through non-payment of their bills. To permit them to do so is unfair and gross discrimination against good-paying patients. Therefore the judicious use of a reliable collection service is advisable —not only to protect the doctor's financial interest, but also in fairness to the conscientious debtor who pays satisfactorily.

When Should An Account Be Placed For Collection?

Three to four months are ordinarily sufficient to determine the intentions of a debtor. If no response is received during that period, either in the form of part payment, promise of payment or a report of reasons for non-payment, an account is seriously "suspect." In this event, it is best to start professional collection activity at the beginning of the fifth statement period if no response has been received.

Why Use the Bureau of Medical Economics?

The choice of a collection service is important. There are several reasons why doctors should use the Society's own collection service:

(1) *Specialized Service*

The Bureau is the Society's own official business unit —it performs a specialized service for doctors and its procedures are on the professional level—it helps protect the physicians' all-important public relations. This factor is of prime importance. Doctors are under attack by the "socializers" and much of the ammunition relates to fees and collection methods.

The Bureau's technique in handling professional accounts differs from commercial accounts. Those "on the inside" of medical practice are most likely to know and understand the problem fully. The Bureau, however, can be just as tough as others with the debtor demanding tough tactics. Our obligation to the doctor is to collect from those who are able and should pay. No stone is left unturned to induce payment, when professional ethics are not jeopardized.

Not all delinquents are deliberately trying to avoid payment. Many are faced with conditions beyond their control, conditions not uncovered until the Bureau makes its investigations. Ruthless pressure against such debtors often backfires, not only against the individual doctor, but against the profession in general.

(2) *Preventive Features*

Another important service, and one which affects every member of the Society, is the Bureau's role in correcting misunderstandings and grievances arising from the handling of delinquent accounts which might develop into malpractice suits.

The very existence of the Bureau will raise the collection ratio of every doctor in the city and stimulate the business consciousness of the public toward all professional men.

Our credit files, consisting of thousands of bad accounts, accumulated by our collection department, warn the patient that unpaid doctor bills affect his general credit standing, and may affect his installment and charge account buying.

Because we are a non-profit service bureau, operated by and for the Society members, we are unselfishly interested in saving the doctor money by reducing the number of his bad accounts rather than in earning a commission on the accounts unnecessarily placed for collection.

Since we do these things to help prevent bad accounts, it is logical to expect every member to use our collection service when the services of a professional collection agency are necessary. To refer them to a commercial collector deprives the Bureau of a record of these bad accounts which should be in the Bureau's files for the protection of other doctors inquiring about these same debtors.

(3) *Economy*

In addition to these reasons for using the Bureau's collection service exclusively, there is the further factor of low cost. The success of the Bureau has made it possible to maintain the 33⅓% rates on all accounts except where legal action is required, or where the account is forwarded to another agency. The true measure of the efficiency of our service for any individual doctor is the degree of intelligent effort made to recover every dollar that can and should be collected. That Bureau members, in general, approve our collection service is attested by the fact that the volume of our assignments is increasing each month.

R. M. KENNEDY
Executive Secretary

Blue Shield Plan
for Hawaii®

Spiralling Hospital Costs and the Effect on HMSA

J. R. VELTMANN, *General Manager*

HMSA is principally known as the "Doctors'" plan and is sponsored by all county medical societies in the Territory of Hawaii. It is the Blue Shield Plan for Hawaii, but unlike other Blue Shield Plans on the Mainland which cover physician services only, HMSA also offers its members hospital protection. On the Mainland, hospital protection is covered by the Blue Cross Plans.

As a true service plan, HMSA's program began by covering full hospital services to its members. By 1947 the plan was forced to indemnify certain services; ancillary services such as diagnostic laboratory work, drugs and dressings and antibiotics were limited to specific allowances, but the plan continued to cover room and board services at ward rates, operating room and anaesthesia services in full. However, hospital costs continued to increase and the plan was forced to raise its dues to meet the increased cost. Every increase in premiums by the plan resulted in loss of membership, which meant that families with low income, who needed the protection, were not able to continue their membership. HMSA has been able to stabilize its rates since 1951, but during this period hospital costs have continued to increase. During the past three years, HMSA has absorbed nearly $45,000 in additional hospital costs without increasing its premiums to the membership, and was also able to increase benefits to members on three separate occasions. This has been possible because of a large increase in membership during this same period. Our monthly benefit cost tabulations and statistical records indicate that the plan cannot continue to absorb further increases in hospital costs without effecting a rate increase to members. The plan is reluctant to increase rates for a pure economical reason—the segment of the population who need medical protection most will not be able to pay more; therefore cancellation of membership would result. This possibly would increase the medically indigent cases and have a direct effect upon the general health of the community.

Let us examine some of the costs of certain hospital services. Ward rates which ranged from $6.50 to $8.50 per day in 1951 are now $8.50 to $11.00 and admission laboratory services that ranged from $3.50 to $5.00 are now $7.00.

The plan fully appreciates that hospitals are required to increase charges due to higher wage scales and the fact that new methods in medical practices together with new drugs have reduced the average stay in the hospital; however, with an increased number of people covered by hospital plans, more people request hospitalization for early treatment of a medical illness with the knowledge that a large portion of the hospital bill will be paid by the medical plan.

In a recent survey, we found that over 77% of the member's hospital bill is covered by HMSA. Eight per cent of the remaining charges represented services for private or semi-private room accommodations, which are not covered by the plan and the remaining 15% was for diagnostic laboratory and x-ray services and other elective incidentals, which are exclusions under the majority of HMSA plans. Hospital bills for which the plan pays between $300.00 and $500.00 are quite common among HMSA members.

HMSA has no working agreement with hospitals and pays retail rates for hospital services. HMSA claim forms are provided each hospital and attending physicians complete a certification for hospitalization. Within a few days after receipt of a hospital claim, it is processed for payment; the member receives a copy of the claim form which shows a detailed breakdown of charges for hospital services rendered and the total amount allowed by the plan for each type of service. Hospitals are paid monthly for services rendered and a copy of each claim is returned to the hospital with such payment. Payments are made directly to hospitals; therefore, HMSA membership means guaranteed dollars to hospitals for services rendered.

Customarily, financial arrangement for settlement of a hospital bill is made on admission, but as a result of close liaison with our hospitals, an HMSA member is admitted upon presentation of his membership card alone.

With close liaison between the hospitals and HMSA, hospital increases are made only upon 30 days' notice to the plan. To date, HMSA has been able to absorb the increased charges but our major concern is to continue to provide members with the best hospital coverage possible on a service basis and still maintain rates within the ability of the public to pay. To do this, doctors, hospitals, members, and the plan must all work together to find some means to curb the ever spiralling hospital costs.

County Society Reports

Hawaii

The August meeting of the Hawaii County Medical Society was held at the Hilo Country Club, August 26, 1954, with dinner at 8:00 p.m. Members present were: Drs. Crawford, Kasamoto, Kutsunai, Loo, Matayoshi, Mitchel, Miyamoto, Okumoto, Oto, Paynter, Tomoguchi and Woo.

From 9 to 10:00 p.m. there were showings of movies. One was on "Use of Hydrocortone" and the other was on "Gastroscopic Examination of the Stomach Pathology." Business meeting began at 10:00 p.m. Membership applications from Drs. Poulson and Cookingham were referred to the Credential Committee.

The Chair brought up the question of membership applications from doctors who are not licensed in the Territory. After much discussion it was moved by Dr. Crawford and seconded by Dr. Woo and was unanimously passed that "the County Society create courtesy membership for those physicians who are graduates of accredited medical schools, but are ineligible for membership due to lack of license. These members shall enjoy all privileges of the Society, except: (1) they will have no voting power, (2) they will be ineligible to hold office, (3) they will not be subject to payment of dues." This amendment to the by-laws is to be sent to all members for consideration and voting at the next regular meeting.

Communications:

1. Letter from Dr. K. S. Tom regarding the scheduled meeting with the Hawaii Medical Association's Subcommittee on the study of maternal, neonatal and fetal deaths, on October 28, 1954, requesting the change of the meeting date a month early or later. A motion was made by Dr. Loo and seconded by Dr. Crawford and unanimously passed that the County Society request a dinner meeting with this group in September.

2. The letter from Hawaii Community Chest and Council dated July 30, 1954 from Mr. Leonard Hurst was read. After some discussion it was moved by Dr. Loo and seconded by Dr. Miyamoto and unanimously passed that the Society request the Community Chest that the solicitation be made by them on individual basis and not through Association plan.

3. Letter from American Diabetic Association, Inc., dated July 9, 1954 was read. After some discussion it was moved by Dr. Woo and seconded by Dr. Crawford and unanimously passed that the Hawaii County Society form a Diabetic Committee. The Chair appointed Dr. Woo as chairman of the committee and to pick his own members.

SADAICHI KASAMOTO, M.D.
Secretary Pro Tem

The September meeting was held at the Hilo Yacht Club at 7:00 p.m., September 23, 1954. Doctors Bergin, M. H. Chang, Crawford, Haraguchi, Henderson, Jenkin, Kasamoto, Kutsunai, Loo, Matayoshi, Miyamoto, Kaufmann, Oakley, Okumoto, Orenstein, Paynter, Stemmermann, E. Wong, Woo, Yamanoha, Yuen, Archer, Cookingham, Poulson and Wipperman were present.

The first portion of the meeting was held as a combined meeting of the Society and the Subcommittee of the Territorial Medical Association dealing with maternal, neonatal and fetal deaths. Doctors Marie Faus, William Walsh, Satoru Nishijima, H. E. Bowles, E. Mei and Kemp represented this committee. There was a short discussion as to the significance of the statistics of fetal and maternal deaths on the various islands and among the various races. Following this, three cases were discussed with a view to trying to fix responsibility for two cases of fetal deaths and one case of maternal death. This was a most interesting session. Following this Dr. Faus described the "Means Test" as applied to child health conferences. After a short discussion of this subject, the committee meeting was closed and the business meeting of the County Society commenced.

The applications of Doctors Cookingham and Poulson for membership in the Society were unanimously accepted. The change in the constitution proposed during the previous meeting was unanimously accepted. This change is in a form of an amendment which will allow physicians who are not licensed in the Territory to become courtesy members of the County Society. They shall enjoy all privileges of the Society except:

1. They have no voting power.
2. They will be ineligible to hold office.
3. They will not be subject to the payment of dues.

It was decided to go forward with plans for a "Diabetes Detection Week" in November. The chairman of the Diabetes Committee, Dr. T. D. Woo, outlined plans for publicity and a short discussion followed.

The meeting was adjourned at 10:45 p.m.

GRANT N. STEMMERMANN, M.D.
Secretary

Honolulu

The regular monthly meeting of the Honolulu County Medical Society was held Tuesday, September 7, 1954 at 7:30 P.M. in the Mabel Smyth Auditorium. Dr. C. M. Burgess presided and approximately 90 members and guests attended.

An excellent Symposium on Roentgenology was presented by the Program Committee:

1) Roentgenography in the Acute Abdomen—Dr. Peter Washko

2) Asymptomatic Intra-Thoracic Neoplasms—Dr. Louis Buzaid

3) Visualization of Tiny Pulmonary Infiltrations—Dr. George Henry

A question and answer period followed.

The membership enjoyed a color movie entitled "Hydrocortone by Intra-Articular Injection."

The question of physicians' listings in the classified section of the Telephone Directory was discussed in detail. Upon the recommendation of the Medical Practice Committee, approved by the Board of Governors, it had been felt that some of the abuses now evident in the Directory could be eliminated by abolishing the specialty section. Instead they advised that listings of doctors' names in the yellow pages of the Directory be confined to a single alphabetical listing under the heading "Physicians and Surgeons (M.D.)." A vigorous pro and con discussion ensued and the following was decided:

That the Medical Society request its members to confine their names to one heading only in the specialty section in the yellow pages of the Directory;

That the Medical Practice Committee review the next edition of the Directory and report their findings concerning the specialty section to the Board of Governors.

There being no further business, the meeting adjourned at 10:00 P.M. and refreshments were served on the Lanai.

J. M. FELIX, M.D.
Secretary

Kauai

The regular monthly meeting of the Kauai County Medical Society was held at Wilcox Hospital, September 14, 1954, at 7:30 p.m., President Kim presiding.

Members present: Doctors Kim, Cockett, Ishii, Fujii, Wallis, Goodhue, Kuhlman and Boyden. Guest: Dr. Schilling.

A communication was read from Dr. Connor in which plans were outlined for conducting hearing tests and otologic clinics for certain segments of the public schools. This proposed action was approved by the Society.

WEBSTER BOYDEN, M.D.
Secretary

Maui

The Maui County Medical Society met at the Central Maui Memorial Hospital on Tuesday, June 8, 1954. Those present were Drs. Ferkany, Rockett, Burden, Kanda, Tompkins, Izumi, Ohata, Sanders, Patterson, Haywood, Butler and Wong. Guests present were Drs. Boyd and Totherow.

The application of Dr. Otsuka for membership in the Society was presented as approved by the Board of Governors. It was moved by Dr. Sanders and seconded by Dr. Kanda that Dr. Otsuka be accepted into the Society. The motion passed unanimously.

A letter from the Hawaii Medical Association concerning a voluntary tetanus immunization program for the Territory was read. It was moved and seconded that we approve the program with the injections being given at a maximum fee of $2.00 per injection. The motion passed.

A letter from the Department of Health was read concerning the offering of hearing tests to any 4 to 5 year old child on the island. It was moved and seconded and passed unanimously that the Society go on record as approving this program.

A letter of resignation from Dr. Sau Ki Wong was read. The reason was his leaving the Territory to take a residency. It was moved and seconded that his resignation be accepted.

A letter from Mr. Carl C. Carlson, chairman of the 1955 Community Chest Campaign, was read. This requested that the medical division of the Chest Campaign be conducted within the Society because of the inconvenience caused the doctors at being solicited individually. After some discussion it was moved and seconded that the Chest be requested to contact doctors individually by mail as in the past. The motion passed unanimously.

Dr. Tompkins presented his report as delegate to the recent Territorial Society meeting in Honolulu. This was concerned primarily with a discussion of the Kaiser Medical Plan. Dr. Patterson also presented information about the thinking concerning the Plan among the new officers of the Territorial Society. Apparently most of the opinions rendered at the Territorial meeting were unfavorable. It was felt that wider coverage by our own HMSA organization in order to compete better with outside plans was much to be preferred. Dr. Haywood moved that the Society go on record as favoring a broader coverage, more competitive HMSA plan even if it required a substantial subsidy from the doctors to put it into effect. This was seconded by Dr. Ferkany and passed unanimously.

Meeting adjourned at 10:00 p.m.

* * *

The regular meeting of the Maui County Medical Society was held on Tuesday, August 24, 1954 at the Central Maui Memorial Hospital. Members present were: Drs. Burden, Cole, Ferkany, Fleming, Izumi, McArthur, Kashiwa, H. Kushi, Underwood, Wong, Shimokawa, Patterson and Rockett. Guests present were: Drs. Mei, Rose, Boyd, Totherow and Faus, Mr. Sheffield, Mr. Veltmann and Mrs. James.

Applications for membership from Doctors Totherow, Boyd and Archer were received and referred to the Board of Governors.

A discussion of the new free choice of physician for industrial accident cases as it applies to Maui Pineapple Company was presented by Mr. Sheffield.

Mr. Veltmann presented an outline of the Kaiser Medical Plan and discussed the various factors involved in HMSA's matching of such a plan. Further comments were delivered by Dr. Faus. Dr. Rockett moved that the Maui County Medical Society request HMSA to begin study at once on the development of a full coverage medical plan for the Island of Maui, including the sugar industry here. The motion was seconded by Dr. Fleming. Mr. Veltmann suggested that a committee be appointed from the Maui County Medical Society to work with HMSA and local hospitals in the development of such a plan.

There being no further business the meeting was adjourned.

L. S. ROCKETT, M.D.
Secretary-Treasurer

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Notes and News

Travellers . . .

. . . to Hawaii

Returning to the Islands for a visit after seven years, were **Dr. and Mrs. R. E. Cloward** of Los Angeles. Dr. Cloward, well-known Honolulu otolaryngologist, retired from active practice several years ago. He devotes part of his time to painting.

Also returning for a short interim visit was his son, **Dr. R. B. Cloward,** who at present is head of the Department of Neurosurgery at Billings Hospital, University of Chicago.

Also returning to Honolulu were **Drs. R. F. Bailey, F. F. Alsup, Benjamin Li, Clarence J. Kusunoki, Colin C. McCorriston, Shoyei Yamauchi, Harold Moffat, Albert K. T. Ho, H. McCleod Patterson, Masato Mitsuda, Wayne Wong, Tadao Hata** and **James Marnie.**

. . . to the Mainland

Dr. Joseph Palma of the Straub Clinic left to attend the American Academy of Pediatrics in Chicago and the New Orleans Clinical meeting in New Orleans, La.

Dr. Ted W. S. Chong left Honolulu to be associated with Dr. H. Shipps, Chief of Gynecology at the Cooper Hospital, Camden, New Jersey, and Chief of Obstetrics at Zurbrugg Hospital, Riverside, New Jersey. Dr. Chong will be away for an indefinite length of time.

. . . to Mexico

Dr. Philip M. Corboy left on a fishing trip. He visited Acapulco, Mexico City and Mazatlan.

. . . to the Philippines

Dr. Richard K. C. Lee, President of the Board of Health, represented the U. S. at the fifth regional meeting of the Western Pacific Division of the World Health Organization in Manila.

. . . to the Orient

Drs. P. S. Irwin, Katherine Edgar, Arthur V. Molyneux, Katsumi Katsura and **Masato Mitsuda** spent September in Japan. In Tokyo the Honolulu physicians participated in discussions on diseases influenced by dietary and racial differences. They also visited institutions caring for atom bomb patients from Hiroshima and Nagasaki.

Our editor, **Dr. Harry Arnold, Jr.,** has been touring Army Hospitals in Japan, Okinawa and Korea, as consultant in dematology to the Surgeon General of the U. S. Army. During this tour Dr. Arnold addressed the staffs of the hospitals he visited on various dermatologic problems.

. . . to Europe

Dr. and Mrs. Louis Gaspar are touring the British Isles, Belgium, Holland and the Scandinavian countries.

Congratulations for . . .

. . . wedding bells

On September 9, 1954, **Dr. Alfred S. Hartwell** and Mrs. Helena P. Dawley were married at the Pilgrim Chapel of Central Union Church.

. . . the stork's visit

Dr. and Mrs. John Lowrey announce the birth of their first son, Michael Wishard, born on August 30, 1954.

Dr. and Mrs. Clifford T. Druecker are the proud parents of a boy, their second son, Mark Thomas, born on August 7, 1954.

Dr. and Mrs. John C. Milnor announce the birth of their second daughter, Jean Anne, born on September 21, 1954.

Dr. and Mrs. Philip S. Arthur announce the birth of a son, Paul Francis, their fifth child, born on October 13, 1954, at St. Francis Hospital.

. . . an anniversary

To our beloved **Mrs. Edith Bennett** on her tenth anniversary as Secretary of the Hawaii Medical Association.

. . . a new job

To **Dr. Walter B. Quisenberry** on his recent well deserved appointment as Executive Director of the Hawaii Cancer Society.

X-Ray . . .

. . . and radio-isotopes

Dr. Edgar S. Childs returned from the mainland following three years of graduate study in radiology. Dr. Childs was a trainee of the National Cancer Institute. He received his training at the Graduate School of Medicine and the Graduate Hospital of the University of Pennsylvania. His studies included training and clinical experience in the use of radio-active isotopes both at the Graduate Hospital and at Oak Ridge, Tennessee. Dr. Childs is certified in radiology by the American Board of Radiology and is a fellow of the American College of Chest Physicians.

Jun-ch'uan Wong, M.D., Ph.D. has been appointed Associate Radiologist and radiological physicist at the new Radio-isotope Laboratory of Queen's Hospital. Dr. Wang is a graduate of the University of Minnesota Medical School. He interned at Asbury Hospital, Minnesota, followed by a residency in biophysics at the Mayo Clinic and a residency in therapeutic radiology at the University of Minnesota Hospital. He was in the Army for two years during which time he served as Chief of the Radiology Department of the Hospital at Fort Leavenworth, Missouri, and radiologist at Brooke Army Hospital, San Antonio, Texas. Dr. Wang is certified by the American Board of Radiology and Radiological Physics. He is the author of several scientific papers. He is married and has three children.

Return . . .

. . . of a kamaaina

Dr. Louise Childs returned from three years stay on the mainland. While away Dr. Childs was instructor in pediatrics at Jefferson Medical College, the first woman on the teaching staff of that institution. In line with her interest in pediatric endocrinology, she attended clinics given by Dr. Lawson Wilkins at Johns Hopkins University, and a graduate course by Dr. Nathan Talbot of the Massachusetts General Hospital. She also attended the meetings of the American Academy of Pediatrics of which she is a fellow. Dr. Childs plans to re-enter practice after the first of the year.

New Shingles . . .

. . . in ob-gyn

Dr. Sydney T. Fujita announces the opening of his office at 911 Keeaumoku Street for the practice of obstetrics and gynecology. Dr. Fujita graduated from Temple University. He interned at St. Francis Hospital, Honolulu, followed by a residency in obstetrics and gynecology at Loyola University School of Medicine, Chicago. For the past two years Dr. Fujita was assigned to the Department of Obstetrics and Gynecology at Tripler Army Hospital. Dr. Fujita is married and has two daughters.

Dr. T. Robert White announces the opening of his office for the practice of obstetrics and gynecology at 22 Oneawa Street, Kailua. Dr. White graduated from Harvard University School of Medicine. His medical education includes one year's fellowship in surgical pathology at Johns Hopkins University, internship for a year at the Baltimore Union Memorial Hospital and one and a half years at Queen's Hospital, Honolulu. Dr. White served in the Air Force for four years, attaining the grade of major. He is certified by the American Board and is a member of the American Academy of Obstetrics and Gynecology.

Dr. Laurence G. Thouin announces the opening of his private office for the practice of obstetrics and gynecology at 204 King Kalakaua Building. He is certified by the American Board and is a member of the American Academy of Obstetrics and Gynecology.

. . . in internal medicine

Dr. K. C. Kenneth Lou is announcing the opening of his office for the practice of internal medicine at 1115 Young Street. Dr. Lau graduated from Hahnemann Medical College. He interned at St. Luke's Hospital, Philadelphia. Dr. Lau was in private practice in New York for 12 years. During this time he was also on the teaching staff of the New York Medical College. Between 1943 and 1946 Dr. Lau served in the Army Air Force. Prior to his coming to Honolulu he was resident physician at Kula Sanitarium, Maui.

. . . in surgery

Dr. George H. Nip announces the opening of his office for the practice of general surgery in the Alexander Young Building. Dr. Nip is a graduate of the University of Hawaii and the Boston University School of Medicine. He interned at Long Island College Hospital, Brooklyn, New York. Following his internship he served for two years in the Medical Corps of the U. S. Army. He then served four years of surgical residency at the Long Island College Hospital. Previous to his return to the Islands he was instructor in surgery at the College of Medicine of the State University of New York. Dr. Nip is certified by the American Board of Surgery. He is married and has a son.

. . . in general practice

Dr. Edward Y. Yomodo announces his association with **Drs. Toshimo** and **Soiki** at 3484-A Waialae Avenue. He graduated from Western Reserve University School of Medicine. He interned at Memorial Hospital, Worcester, Massachusetts, then served one year's residency at Queen's Hospital, Honolulu.

Old Shingles . . .

. . . new addresses

Medical Associates is the name of a group formed by **Drs. Duke Cho Choy, Albert H. Ishii** and **Roy T. Tonoue** at the Medical Arts Building, 1010 South King Street.

Dr. Shoyei Yamouchi also announces his new location in the Medical Arts Building, 1010 South King Street.

Presenting papers . . .

. . . in Honolulu

Drs. N. P. Lorsen, Mosoto Hosegowo, W. Horold Civin, Hon Chong Chang, Leslie Vosconcellos, and **Laurence Wiig** spoke before the Hawaii Cancer Society on the subject of "How Can Cancer Be Detected Early Enough to Offer Hope."

Dr. Dorothy S. Notsui addressed the Honolulu Society of Dentistry for Children on the subject of "The Fear Reaction in Children." She emphasized the difference between real fear, such as caused by being in a dentist's chair, as opposed to neurotic fear.

Dr. William Stevens discussed "Methods of Psychotherapy for the General Practitioner" at the Territorial Association of Plantation Physicians annual meeting.

. . . in New York

Dr. F. J. Pinkerton talked to the Academy of Ophthalmology and Otolaryngology on the subject of compensation and pension rackets among veterans. He attributed such malpractices to faulty physical examinations and records made during the induction of servicemen.

Dr. William John Holmes spoke on "Changing Concepts of Ocular Leprosy" before the XVIIth International Congress of Ophthalmology.

. . . in Geneva, Switzerland

Dr. T. Robert White gave a paper at the International Congress of Obstetrics and Gynecology on "Practical Experience with the Papanicolaou Stain."

Talent . . .

. . . on stage

Dr. Nils P. Lorsen conceived, wrote and staged a pageant commemorating the Evolution of Surgery in the Pacific. The pageant was presented on the occasion of the dedication of the new addition to Queen's Hospital. It traced the history of the healing arts of the Pacific from bamboo scalpels used by early Fiji physicians to elaborate rites of Oriental doctors. Hawaiian Kahunas, knife wielding Fijians and the influence of early European medicine as practiced by missionaries were ably demonstrated during this memorable pageant. Dr. Larsen was assisted by **Drs. W. S. Ito, K. Okozoki,**

T. F. Fujiwara, Howard Liljestrand, H. Q. Pang, Richard Sakimoto, C. M. Burgess, H. M. Johnson and a cast of approximately 300 others.

. . . on screen

Playing the part of a colonial officer in the Warner Bros. movie production "Mr. Roberts" is **Dr. Clarence E. Fronk.** Other actors starring with Dr. Fronk are Henry Fonda, William Powell and James Cagney.

New Officers . . .

. . . TAPP

Territorial Association of Plantation Physicians: President, **Dr. J. Alfred Burden,** Paia, Maui; Vice President, **Dr. Marvin A. Brennecke,** Waimea, Kauai; Secretary-Treasurer, **Dr. Frank H. Hatlelid,** Waialua, Oahu; Executive Secretary, **Mrs. Jeanette Wilkinson,** Honolulu.

. . . Ob-Gyn

Honolulu Obstetrical and Gynecological Society: President, **Dr. James Wong;** Vice President, **Dr. R. West;** Secretary-Treasurer, **Dr. F. Carty.**

. . . Pan-Pacific

Pan-Pacific Surgical Association: **Dr. Arthur W. Allen,** Boston, Massachusetts, President; **Dr. Joseph E. Strode,** Honolulu, First Vice President; **Dr. Ian Hamilton,** Adelaide, Australia, Second Vice President; **Dr. Young So Kim,** Pusan, Korea, Third Vice President; **Dr. John P. Frazer,** Honolulu, Secretary-Treasurer; Regular members of the Council from Hawaii: **Drs. John Lowrey, Robert T. Wong,** and **Robert Johnston; Douglas Bell, Paul W. Gebauer** and **Tadao Hata;** Alternate members: **Drs. Satoru Nishijima, Burt O. Wade** and **Howard Crawford;** Regular members of the Council from the mainland: **Maj. Gen. George Armstrong, Drs. Leon S. McGoogan, Frank Gerbode, George Shambaugh** and **Franklin Payne;** Alternate members: **Drs. Robert E. Schmitz, Herbert Willy Meyer** and **Claude S. Beck.** Director General: **Dr. Forrest J. Pinkerton,** Honolulu.

The Sixth Congress of the Pan-Pacific Surgical Association convened in Honolulu between October 7 and 18. It was attended by a total of approximately 800 registrants who came from Hawaii, the mainland and foreign countries. About 150 scientific papers were read. As usual a great many social events were scheduled during this meeting. They included a golf tournament, reception by the out-going president, by the Governor of Hawaii, numerous cocktail and dinner parties by Honolulu physicians, a luau, and sightseeing in and about Honolulu and on the outside islands.

Island News . . .

. . . from Hawaii

Drs. Don E. Poulson and **Cory E. Cookingham** are now working as assistant physicians in the Pepeekeo Plantation medical clinic.

Dr. Rudolph Wipperman has returned to Hilo and has resumed his practice after having served in the Army.

Dr. and Mrs. James Mitchel are the parents of a baby girl. They now have one son and three daughters.

Dr. R. H. Gray has assumed the position of physician at the Hutchinson Sugar Plantation in Naalehu. He replaces **Dr. R. L. Knotts.**

NEWS

The Van Meter Prize Award

The American Goiter Association again offers the Van Meter Prize award of three hundred dollars and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The award will be made at the annual meeting of the association which will be held in Oklahoma City, Oklahoma, April 28, 29 and 30, 1955, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations; should not exceed three thousand words in length; must be presented in English, and a typewritten double space copy in duplicate sent to the secretary, John C. McClintock, M.D., 149½ Washington Avenue, Albany, New York, not later than January 15, 1955.

Correspondence

To the Editor

The article, "Retroperitoneal Insufflation by the Presacral Route," in the HAWAII MEDICAL JOURNAL of May-June 1954 was of great interest.

The article concludes, "The ease and safety of this procedure is stressed"; yet, on the one occasion on which this procedure was attempted by my associate, the patient died.

The patient, a 42 year old man, was being investigated for pheochromocytoma. A member of the Surgical Service injected 400 cc. of air presacrally. The results of roentgenology were unsatisfactory, so three hours later he injected an additional 800 cc. of air.

About two minutes after the second injection, the patient went into shock, and died within a few minutes.

Post-mortem examination, performed with a technique which would disclose air embolism, disclosed no evidence of such embolism; and, indeed, no cause for death could be established after gross and microscopic examinations.

On one other occasion a patient was referred to me for consultation with a tentative diagnosis of pheochromocytoma. He was accompanied by films taken after presacral injection of air. I do not know the details of this procedure, since it was done elsewhere, but I was unpleasantly surprised to see that this procedure had resulted in a pneumo-pericardium.

In brief, although Dr. Morgan knows far more about retroperitoneal insufflation than I, my limited experience impels me to write this note of warning to my medical colleagues in Hawaii.

ROBERT J. HOAGLAND
Colonel, Medical Corps
Chief Medical Service

U. S. Army Hospital
Heidelberg, Germany.

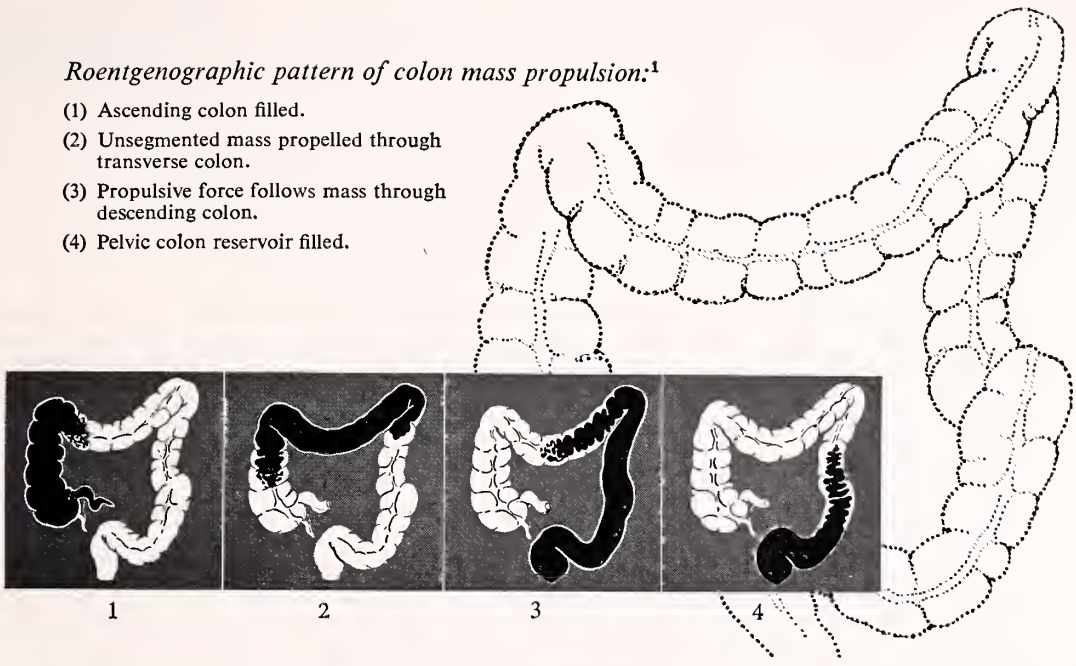
Roentgenographic pattern of colon mass propulsion:[1]

(1) Ascending colon filled.

(2) Unsegmented mass propelled through transverse colon.

(3) Propulsive force follows mass through descending colon.

(4) Pelvic colon reservoir filled.



Reestablishing Bowel Reflexes with Metamucil®

Nervous fatigue, tension, injudicious diet, failure to establish regularity, too little exercise, excessive use of cathartics—all factors which contribute to constipation.[2]

Sufficient bulk and sufficient fluid form the basic rationale of treatment of constipation with Metamucil.

Metamucil (the mucilloid of Plantago ovata) produces a bland, smooth bulk when mixed with the intestinal contents. This bulk, through its mass alone, stimulates the peristaltic reflex and thus initiates the desire to evacuate, even in patients in whom postoperative hesitancy exists.

Factors Contributing to Chronic Constipation

Such gentle stimulation is of distinct advantage in reeducating and reestablishing those reflexes which control bowel evacuation. Many factors may pervert the normal reflexes, causing finally chronic constipation. Among them are: nervous fatigue and tension, improper intake of fluid, improper dietary habits, failure to respond to the call to stool, lack of physical exercise and abuse of the intestinal tract through excessive use of laxatives.[2]

Correction of constipation logically, therefore, lies in the suitable adjustment of these factors. The characteristics of Metamucil permit the correction of most of these factors: it provides bulk; it demands adequate intake of fluids (one glass with Metamucil powder, one glass after each dose); it increases the physiologic demand to evacuate; and it does not establish a laxative "habit." Metamucil, in addition, is inert, and also nonirritating and nonallergenic.

Dosage Considerations

The average adult dose is one rounded teaspoonful of Metamucil powder in a glass of cool water, milk or fruit juice, followed by an additional glass of fluid if indicated.

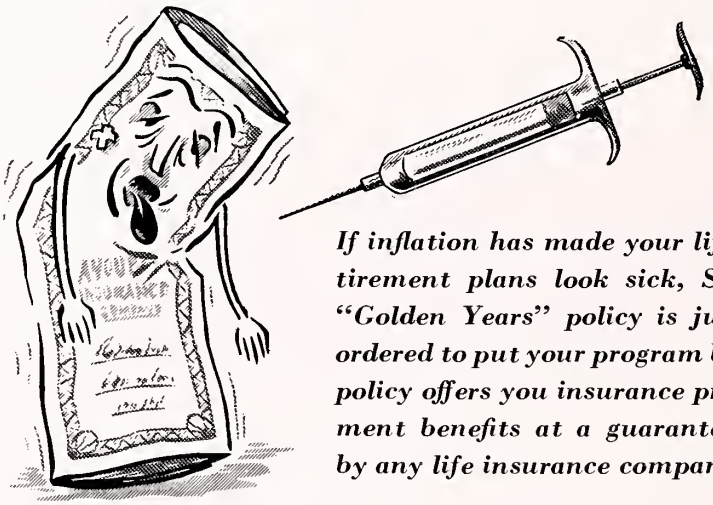
Metamucil is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. It is supplied in containers of 4, 8 and 16 ounces. Metamucil is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

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1. Best, C. H., and Taylor, N. B.: The Physiological Basis of Medical Practice: A Text in Applied Physiology, ed. 5, Baltimore, The Williams & Wilkins Company, 1950, pp. 579-583.

2. Bargen, J. A.: A Method of Improving Function of the Bowel, Gastroenterology *13*:275 (Oct.) 1949.

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INTER-ISLAND NURSES' BULLETIN

Official Publication of the Nurses' Association, Territory of Hawaii

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HAWAII PROGRAM PRAISED

The Institute on Child Growth and Development held at Harvard University, June 17-18, 1954, was made possible by a cooperative arrangement worked out between the United States Children's Bureau and the American National Red Cross. Miss Margaret L. Varley, assistant professor of Public Health Nursing, Harvard School of Public Health, was in charge of the institute under the direction of Dr. Harold C. Stuart, professor of Maternal and Child Health, Harvard School of Public Health.

Forty-one persons from 22 states, Puerto Rico and Hawaii attended the institute. Nurses in attendance represented state, county and city departments of public health, three-year and collegiate schools of nursing, and Red Cross Nursing Services from chapter and national level. All representatives participated actively in the preparation of nurse-instructors in the parent education field. Six resource persons — two from the Children's Bureau, two from the American Red Cross Nursing Services, one from the Boston Visiting Nurse Association, and one from the Boston University School of Nursing—participated throughout the two week institute.

The faculty of the Harvard School of Public Health gave freely of their time and knowledge, providing excellent background training and up-to-date information to the group. Dr. Pauline Stitt, formerly director of Maternal and Child Health, Bureau of Public Health, Territory of Hawaii, and now a member of the faculty, Harvard School of Public Health, presented the lecture on "Normal Physical Growth and Development of the Infant from Birth to One Year." During the program planning group discussion, Dr. Stitt praised the cooperative Mother and Baby Care, parent education program in the Territory of Hawaii. The Hawaii program compares favorably with mainland programs, and in some phases of planning is more advanced.

Some of the highlights of the basic concepts of Mother and Child Care were:

> Having a baby, for a well woman, is a normal physiological process and should be satisfying and rewarding. The whole body is considered to be pregnant rather than the uterus alone.
>
> Accompanying pregnancy are many natural anxieties for both expectant parents but these are usually worked through satisfactorily.
>
> Joint planning for family building is important, and the family should have a sense of pride in the mother's presentation of a new baby.
>
> The nutritional status of the mother is important beginning with her birth and continuing during her entire life, and particularly at conception and during pregnancy and lactation.
>
> The nurse plays an important role in helping meet the mother's needs by giving emotional support and guidance in helping the mother understand the changes that are taking place and what she can do about them; by helping to build environmental support by assisting the family to come to the support of the mother; by being aware of evidences of stress situations and helping to meet them; by understanding her own feelings as well as the mother's feelings and reactions and being able to accept the mother's wishes rather than imposing her own.
>
> A modern concept of the maternal cycle is that it extends from the birth of the mother to her own postmenopausal period. Of special significance is the menopausal period since this often occurs concurrently with the adolescent stage of her children.

All children differ from one another as to rate and degree of growth, but for all of them there is one common aspect of growth—that of predictability of sequence. Knowledge of this sequence of the events in growth makes possible anticipatory guidance for parents so that they too may have the exciting experience of anticipating and catching each new development in its turn. In other words they are prepared for what is to come "just around the corner" and find it easier to have the understanding and patience needed to assist the child all along the way.

Building a healthy mother-child relationship is important in the continued healthy emotional development of the child. A healthy mother-child relationship has been defined as characterized by a mother's reactions to her child primarily on the basis of her awarenes of his needs and her attempt to satisfy them; whereas, in an unhealthy mother-child relationship, the expectant mother may use the child for fulfilling her own needs.

As a means of gaining a better understanding of the art and skill in leading group discussion effectively some basic concepts in regard to the democratic procedure were presented; the initiation of independent thinking; building on the usual rather than the unusual; building upon the experiences of the group as well as experiences of individuals; utilizing the strengths and being alert to the attitudes and feelings of the "inner man," seeking to help him develop a reasonable sense of security and the ability to think independently; and considering at all times the importance of correct timing, state of readiness and interest.

The institute was highly successful, as evidenced by the enthusiastic statements of those who attended. The smoothness with which the sessions were conducted showed that much preliminary planning and organization had been done. There was excellent teamwork by the members of the faculty in presenting material and relating pertinent facts from each session.

Together with the institute held in 1952, which was attended by Mrs. Esther Stubblefield and Mrs. Mabel Snyder, this institute should contribute significantly toward improvement of mother and baby care and parent education in the United States and its territories.

MARY V. NEAL
Director, Nursing Services
American Red Cross, Hawaii Chapter

NATIONAL NURSE WEEK

NATIONAL NURSE WEEK, 1954, is a reality!

President Dwight D. Eisenhower launched the national observance by signing into law on August 24 the bill which authorizes the proclamation of October 11 to October 16, inclusive, 1954, as NATIONAL NURSE WEEK "in honor of the professional nurses of America and in recognition of the vitally important services they render in the promotion of national health and welfare." The proclamation reads in part ". . . it is proper and fitting that national attention and recognition should be focused on the great contributions, past and present, that the nursing profession in all its branches has made to the national welfare and security."

Based on the theme that "Progress in Nursing Means Better Health for the Nation," NATIONAL NURSE WEEK will focus public attention on the progress of nursing and nursing education and the major role nurses play in the health care of the nation. It provides an opportunity to dramatize and interpret the services and requirements for providing adequate nursing care and nursing education, as well as recruit young women to the profession. It also gives members of ANA the opportunity to acquaint non-nurse members with the aims, goals and work of the organization.

Everyone has a stake in good nursing and communities can be helped to think of their responsibilities toward nursing, especially during the "week." It is imperative that the public know that the nursing profession itself is doing its share in promoting better health for the public through programs supported by the ANA. Among the programs of note are state laws which provide for licensure of professional and practical nurses; provision for nursing service in health insurance programs and medical care plans; federal and state measures designed to aid nursing education, especially through scholarships for graduate nurses and students in basic nursing courses in colleges and universities, and the vital role of nurses as essential participants on the "health care team."

It is also fitting to commemorate the centenary of Florence Nightingale's dedication to nurse the sick and wounded on the battlefields of the Crimea. Today, there are nearly 400,000 registered professional nurses and 75,000 licensed practical nurses who are currently providing nursing care in America's hospitals, health agencies and homes; however, more nurses are needed to meet the demands for nursing service. Health education programs are influencing more and more people to seek medical and nursing care. New drugs and new treatments in medicine require more and better nurses. It is estimated that approximately more than 50,000 professional nurses and 60,000 practical nurses are needed to meet the essential civilian demands for nursing service.

Quality nursing care and quality nursing education can only result from public acceptance of the concept that the nursing profession does play a

vital role in the health care of the nation, and the many problems which currently confront the nursing profession can only be solved through the aid of an informed and sympathetic public.

ARE NURSES BEING TAKEN AWAY FROM THE BEDSIDE TODAY?*

Many of us have heard the complaint that today nurses are being taken away from the bedside.

Those who attended the ANA convention heard an authoritative answer to that complaint from Marion Wright, associate director, Harper Hospital, Detroit, at a General Duty Nursing section meeting. Requests have been made to include some of her comments in this newsletter.

"We are not taking the nurse from the bedside but putting her back," Miss Wright maintained, in explaining the team concept. "We are removing extraneous functions of cleaning, clerical work, preparing equipment, all of the things that kept her in the nurses' station or in the utility room. Now she is out among the patients assigned to her and her personnel most of the time, except when they are having the planning conferences which are so necessary or preparing medications or treatment trays to take to the bedside. She is closer to the patient than she ever was before."

In this form of nursing care, leadership skills of the general duty nurse are most important, human relations and recognition of the worth of individuals are prerequisites, she said.

The professional nurse is the leader, the patient and co-workers will be assigned to her, not to work for her, but with her. She must be able to pull the group together into a working relationship where everyone does his best.

Communications skills are a must; attitudes are also most important. The nurse has a two-fold teaching function with the patient and his family and with other workers, Miss Wright said.

FEW NURSES PROTECT THEMSELVES AGAINST LIABILITY†

Only a small percentage of nurses in ANA have taken advantage of the professional liability insurance available to them through the association. This, despite the continuing tendency for the public, the courts and juries to hold nurses liable for their professional acts involving alleged negligence.

This insurance has been available since 1950 under a master policy with St. Paul Mercury Indemnity Company. Annual premium for basic insurance (up to $5,000 for any one claim, up to $15,000 for each annual period) is $10. Higher limits of protection are available at slightly increased costs and unless nurses reside in Louisiana, Texas or New York, they can buy this protection for a three year period at a saving of half a year's premium.

This protection is inexpensive; it meets a need of nurses today. Perhaps the small percentage who have taken it indicates that few know it is available. Talk it up as another service to nurses from their professional organization. Obtain full details from ANA.

THE REGISTERED NURSE VS. THE TECHNICIAN IN THE O.R.

What is the Problem?

"Imagine! She actually scrubs for those specialities as *I* do. Why should I put out so much money, time, and training, and then have to compete with a technician or whatever they call themselves, in order to maintain my status?"

"Yes, Miss A., technician, is doing the cardiac case in Room 3; this gives me an opportunity to see if we really need to put up so many instruments for that case; it certainly would save us much to eliminate the useless ones."

Very informally speaking, here are examples of what is heard in meetings, in the operating rooms, and in private discussions among professional nurses today. The attitude is one of pure non-acceptance and hostility on one hand, to one of practicability with a look to the future on the other. Nurses are apparently well divided upon the subject. Unless there is a thorough understanding of the terms in use, integrated with the functions, standards, and qualifications of each title, and the open recognition for essential nursing services in all fields, no one can rightly condemn or praise either side. The problem, then, comes to this: can nurses conscientiously accept and encourage the non-nurse surgical technician in the role of scrub nurse?

How Did It Become a Problem?

There has always been a need for well trained nurses. A look into the history of nursing describes the constant necessity for education in order to fulfill the demands of the profession by the public. General world conditions have been great influencing factors in changing educational and service concepts of nursing. Perhaps World War II has increased and emphasized the acute call for masses of nurses. Where the supply could not meet these requests, other auxiliary workers in all levels were substituted. The new assistants have become more widely trained and organized, to a de-

* Reprinted from *Stat Chat*, Vol. I, No. 1, August 1954.
† Reprinted from *ANA Guide Lines*, Vol. V, No. 8, August 1954.

gree, which has created a more concrete need for further defining of professional nursing duties.[1] Whereas, the graduate nurse of yesterday was trained more specifically for manual skills, along with a close "lady-in-waiting" patient relationship, the one of today must have developed more particular techniques in the matters of skilled observation with appropriate guidance of action for the best total patient care.[2]

This more complex aspect of nursing with the definite establishment of a new form of co-worker has grown rapidly. Many nurses are completely unaware of their new allies until they are suddenly in the middle of a practical situation.[3]

Why Is It a Problem?

Registered nurses present "two arguments which indicate sincere anxiety; in one instance, anxiety concerning patient care, in the other, anxiety about the R.N.'s own future."[4] The relinquishing of such technical, though repetitious, duties to those who have not experienced the longer trials and tribulations of a basic dictatorial orientation is a hard matter for some to accept. The above method of instruction restricted the performance of procedures according to the exact form with little room left for inspiration and growth. Perhaps it is an absence of current knowledge which causes the nurse to continue to believe that no one but a graduate nurse can minister care to a patient. Surely, if a nurse becomes so concerned with such thoughts, she is unable to objectively view the *total* program of nursing care, and, what is more important, forget that the only reason for a nurse's existence is the patient.[5]

How Can It Be Solved?

First of all, think of the basic definition of the word *technician:* "A person skilled in techniques or in some practical art or arts."[6] The words "non-nurse" and "surgical" describe the type of job and the speciality therein, giving further characteristics of the technician. The main function of a technician is to give supplementary assistance to the professional nurse. The standards involve knowledge, skill and ability taught by the professional nurse. The qualifications, though not clearly defined at the present time, implicate a specified amount of practical training either on the job or in a formal course with instruction by a professional nurse.

Next, consider the definition of nursing as described by Sister M. Olivia of the Catholic University of America: "Nursing in its broadest sense may be defined as an art and a science which involves the whole patient—body, mind, and spirit; promotes his spiritual, mental, and physical health by teaching and by example; stresses health education and health preservation, as well as ministration to the sick; involves the care of the patient's environment—social and spiritual as well as physical; and gives health service to the family and community as well as to the individual."[7]

Certainly it is apparent that nursing today involves competence far above and beyond that which is called for in the role of scrub nurse. The professional nurse is needed, without a doubt, in the operating room. The performance of such procedures which are now commonly delegated to the technician is actually a limitation of the nurse's qualities. She is far more valuable in guiding and teaching the technician to assume prescribed responsibilities in order to release herself to perform more professional skills.

This is more than just a theoretical approach. Sister Mary Carmen of St. Francis Hospital in Pittsburgh, Pennsylvania, instituted a six-months training program for surgical technicians in the operating room in 1951, with a gratifying report of increasing success.[8] Miss Bell of Harper Hospital in Detroit, Michigan, has also reported on the advantages of operating room technicians.[9] From the writer's personal observations in the Henry Ford Hospital in Detroit, Michigan, and the University Hospital, Ann Arbor, Michigan, the performance of the technician was excellent. They displayed an even greater meaning of teamwork. Though only a few reports of the clinical use are mentioned here, they may help to illustrate how such programs can be successfully done. There were many initial difficulties in setting up the programs and the personnel selected to enter into the training were carefully screened. There is still a great deal to be done for all members of the team; each needs more clearly defined duties and responsibilities in order to fit more smoothly into the total operating room picture.

Conclusion

In summary, the following statement seems appropriate. "Professional nurses need have no fear for their security, as long as they maintain their own standards, are aware of changing conditions, and continue to focus attention on nursing to meet community needs."[10]

[1] Ella Thompson, *Am.J.N.*, May, 1952, p. 594.
[2] Janet Geister, *RN*, December, 1953, p. 49.
[3] Janet Geister, *RN*, February, 1954, p. 39.
[4] Esther Brown, *Nursing for the Future*, p. 61.
[5] John Dolan, *Yearbook from Hospital Topics*, 1952, p. 4.
[6] Funk and Wagnalls, *College Standard Dictionary*, p. 1152.
[7] Esther Brown, *Nursing for the Future*, p. 74.
[8] Sister Mary Carmen, *ORS*, December, 1953, p. 7.
[9] Harriett Bell, *Am.J.N.*, May, 1952, p. 581.
[10] Ella Thompson, *Am.J.N.*, May, 1952, p. 595.

Again, it seems fairly simple to put this in writing. However, professional nurses need to be actively aware of this situation; to read, observe, and participate in developing their appropriate attitudes for continued growth in and with their chosen profession. Then, and only then, can registered nurses accept with open minds and hearts these essential members of their teams. Will YOU accept them?

COLENE SMITH, R.N.

PRIVATE DUTY NURSES DO NOT STAND ALONE*

The combined effort of all nurses within ANA has made possible active support of legislation which has benefited private duty nurses.

Such measures have included: amendments to improve Federal social security; changes in income tax laws to lessen unwarranted burdens for private duty and other nurses; removal of discrimination based on race, creed, color, religion, national origin, or marital status.

Working together as we do has also made it possible to obtain legal interpretations regarding the status of private duty nurses in relation to social security and income tax laws and legal rights of sections to establish fees.

A third advantage of such joint effort through ANA is that we have a source of information about such laws and how they apply to us. For example, there have been several queries about the new unemployment compensation law (Employment Security Administration Financing Act). If you have any questions contact the ANA Economic Security Unit, Attention, Miss May Bagwell, Industrial Relations Consultant.

THE ANGEL OF DIEN BIEN PHU

On May 25, 1954, Mrs. Frances P. Bolton submitted the following concurrent resolution in the House of Representatives. On June 3, 1954, it was reported out of the Committee on Foreign Affairs without amendment and passed.

Concurrent Resolution

WHEREAS this year marks the one hundredth anniversary of Florence Nightingale's historic nursing of the wounded in the Crimean War; and

WHEREAS Nurse Genevieve de Galard-Terraube, officer of the Army of the Republic of France, in her ministering to the sick and wounded at Dien Bien Phu and her subsequent service to her comrades as prisoners of the Viet Minh has provided an example of the courage of a woman in battle and of the devotion of a nurse to her sworn duty which has been unsurpassed in this century; and

WHEREAS this inspiring woman is representative of the devotion to duty of soldiers of the Republic of France, which has been an ally of the United States for one hundred and seventy-eight years and whose people today are considered the warm friends of the people of the United States; and

WHEREAS Nurse Genevieve de Galard-Terraube's example of fortitude in the face of supreme danger has changed the fall of Dien Bien Phu from a military reversal to a great psychological victory of the undefeatable principles of free mankind fighting the force of darkness; and

WHEREAS this nurse, known affectionately as "The Angel of Dien Bien Phu" embodies the finest attributes of free women accepting with men the full burden of living in our modern world: Therefore be it

RESOLVED BY THE HOUSE OF REPRESENTATIVES (THE SENATE CONCURRING), That the Congress hereby extends to Nurse Genevieve de Galard-Terraube its warm congratulations for her gallant service and invites her, at the earliest time convenient to her and her country, to visit the United States as an honored guest.

The President is respectfully requested to transmit copies of this resolution to the Government of France, and to Nurse Genevieve de Galard-Terraube.

Mademoiselle Genevieve de Galard-Terraube, the French nurse who has become known as the "Angel of Dien Bien Phu," toured the United States for approximately three weeks, as a guest of the government of this country, under the U. S. State Department's Exchange Program and the special auspices of a national welcoming committee appointed by Representative Frances Payne Bolton of Ohio. The American Nurses' Association was represented on this committee and took part in official functions held.

Nurses the world over are honored by the recognition that is being given to one who has dramatized the faithfulness to duty which is inherent in the Code subscribed to by our profession.

Mademoiselle de Galard-Terraube is a graduate of the School of Nursing, Lisbonne Street, Paris, and has passed the French State examination as a registered nurse. She is a member of I. P. S. A. (Infirmiere Pilate de secours de l'Air—Flight Nursing Group).

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* Reprinted from *Private Duty News*, Vol. II, No. 1, August 1954.

Be Prepared—You may be satisfied now with your work but at some time you may wish to change.

This service is free to members. It avoids constantly writing former employers for references. It is an endorsement that your references have been checked.

Write Leona R. Adam, Professional Counseling and Placement Service, NATH Headquarters, Mabel Smyth Building, 510 South Beretania Street, Honolulu 13, Hawaii.

NURSES' ASSOCIATION, COUNTY OF HAWAII

The Nurses' Association is back in line after a two months' vacation.

Among the members here, there is much discussion and planning about the coming convention to be held in Honolulu on October 13, 14 and 15. Delegates and their alternates are now being chosen to attend this coming convention. Much will be in store for all those who will be in Honolulu for the convention.

The members of the Nurses' Association, County of Hawaii, were honored to have as guests in the meeting which was held on September 7, Miss Rose Hee of Honolulu and Miss Martin of Guam. It was a great pleasure to have them with us.

Personals

Miss Moira Wilson is back on duty at Hilo Memorial Hospital, doing private duty nursing after her 2 months' vacation during which she visited her school of nursing and friends in California.

Miss Noriye Takehiro resigned from Puumaile Hospital recently and has joined the nursing staff of Wilcox Hospital on Kauai. She is a graduate of Queen's Hospital School of Nursing.

Miss Lorraine Aiko Ishikawa recently resigned from the Department of Health, Pahala district, to take on a new position in Honolulu at the Lanakila Health Center. She is planning to continue her studies at the University of Hawaii. She is a graduate of Queen's Hospital School of Nursing.

Mrs. Victoria May Bristow of the Laupahoehoe Hospital has joined the Nurses' Association, County of Hawaii. She is a newcomer to the island.

NURSES' ASSOCIATION, COUNTY OF KAUAI

The Nurses' Association, County of Kauai, held its annual rummage sale at the Kapaa Community Church on August 4 and 5. Co-chairmen Mrs. Clella Cockett and Mrs. Helen MacPherson report the sale was a success. The proceeds of this sale go towards financing two nursing scholarships annually.

This year's winners of the nursing scholarships are Miss Esther Kudaishi, 1954 graduate of Waimea High School, who will attend Queen's Hospital School of Nursing and Miss Gladys Vera Cruz, 1952 graduate of Waimea High School, who will enter Loma Linda Hospital School of Nursing in California.

Wedding bells rang for the following Kauai nurses: Emiliana Daniel to Stanley Shima on June 5; Noriye Takehiro to Iwao Ino on August 14 at Waipahu, Oahu; Florence Muraoka to George Shibano on August 28 at Harris Memorial Church.

Mrs. Josephine Duvachelle of the local Health Department is currently on maternity leave. Replacing her is Miss Nancy Allen of Palo Alto, California, a graduate of the Kaiser Foundation Hospital.

Miss Jacqueline Holt, assistant professor of nursing education, University of Colorado, was instructor for a Workshop of Nursing Supervision in which twenty-seven nurses participated. Those taking the course were: Irene Cabral, Rosario Dela Cruz, Barbara Fujimoto, Grace Furugen, Aurelia Galapon, Evelyn Giles, Nobuko Hayashi, Thelma Hensley, Vina Hutton, Miyoko Iwai, Pauline Johnson, Tsugie Kadota, Esther Kono, Helen MacPherson, Miyoko Masunaga, Hilda Michioka, Elizabeth Middleton, Marlene Nakamura, Peggy Nishimitsu, Ida Oganeku, Martha Ohama, Euphemia Padilla, Mary Paul, Esther Shigeta, Emiliana Shima, Betty Sora, and Edith Yamagata.

Miss Elizabeth Middleton and Barbara Davis left by freighter on September 6 for a three months' vacation to Spain, Portugal and Majorca.

After four years' employment at Wilcox Memorial, Miss Elsie Watanabe, night supervisor, left for Union Hospital in Mayville, North Dakota, on September 11, 1954.

MAUI DISTRICT NURSES' ASSOCIATION

Two new members have joined the staff of Kula Sanatorium. They are: Dolly Dunn, graduate of the Merrit Hospital School of Nursing in San Francisco, California, and Jeanette Nakamura, graduate of Mother Cabrini School of Nursing in Chicago, Illinois.

Miss Linda Lee, Miss Alice Yamashiro, and Mrs. Lorraine Matsumoto have joined the staff of the Puunene Hospital. Both Miss Lee and Miss Yamashiro are graduates of St. Francis Hospital School of Nursing in Honolulu, while Mrs. Matsumoto is a graduate of Queen's Hospital School of Nursing.

Mrs. Bessie Chung, Mrs. Rene Sylva, Miss Lani Ikeda and Miss Alice Yamashiro were accepted as new members of the Maui District Nurses' Association. It may be of interest to know that the Maui District Nurses' Association has reached its membership quota. Maui no ka oi as always.

The public health nurses of the Maui District Association have formed a Sub-unit of the P. H. N. section here on Maui. The following officers were elected:

Chairman	Mrs. Hilda Akana
Vice Chairman	Mrs. Michi Kamitaki
Secretary	Mrs. Okuni Tanner
Executive Committee	Mrs. Gloria Foster
	Miss Margaret Watanabe

Miss Hisako Ogata has left the Puunene Hospital staff and has gone to Chicago, Illinois, where she is now employed by the University of Illinois R. and E. Hospital.

IN MEMORIAM

Grace Charlotte White, supervisor of clinical instruction at Leahi Hospital, Honolulu, passed away on August 27, 1954. Mrs. White had been with Leahi since October 8, 1951, serving until September, 1952, as ward head nurse. From that date until she succumbed to her recent illness she was with the Nursing Education Department.

She attended Marquette University in Wisconsin and in 1924 received an Oconto County Teacher's Certificate and taught in the schools in Oconto Falls, Wisconsin, for several years. However, her one ambition had been to make her place in the nursing profession, and she later

entered the school of nursing in West Suburban Hospital, Oak Park, Illinois, from which she was graduated in 1934.

She continued active in the field of nursing in various parts of the mainland until the death of her husband in 1951, at which time she and her daughter, Penny, took up residence in Honolulu.

Mrs. White was an active member of the Nurses' Association and the League for Nursing and for the past two years served as advisor to the Practical Nurses' Association. It was largely through her interest and guidance that the practical nurses became organized on a territorial level last year.

HAWAII LEAGUE FOR NURSING

Following its reorganization in 1953, the Hawaii League for Nursing has functioned through the following committees:

Operating Room Nursing
Medical and Surgical Nursing
Maternal and Child Health
Education
Administration

A sixth committee, one on Psychiatric Nursing, formed after the last annual meeting, has dissolved because of the few nurses in that specialty.

Each of these committees plans and develops projects individually. Each committee has its own officers and a set of rules and regulations to guide its conduct. However, all committees come together for joint planning for program activities and for membership meetings through a Program and Steering Committee which is composed of the committee chairmen under the direction of the vice president of the Hawaii League. This Steering Committee meets in alternate months with the membership. This group planned one membership meeting on surgical, operating room and home follow-up care of cardiac conditions with representatives from each committee participating. The Administration Committee presented a panel on effective reference writing. The rehabilitation program in Hawaii was discussed at another meeting.

The Hawaii League for Nursing now has 48 members, three of which are non-nurse members. Needless to say, we need more of both groups.

It is hoped that the coming year will bring about increased membership, both nurse and non-nurse, clarification of objectives and more specific delineation of problems needing study in the effort of improving patient care.

VIRGINIA A. JONES
President

PRESIDENT'S ADDRESS

Nurses' Association, Territory of Hawaii, Inc.

October 13, 1954

The mechanics of operating an organization are clumsy, sometimes unwieldy, sometimes vague. Apparently wound with red tape, the democratic process lumbers along. This is true, whether we regard the field of government, industry or nursing. We are glad this is true. It demonstrates a free group of individuals examining their situation, evaluating their position and doing something about it. Nursing is a large field. Let us examine a few statistics. In 1950, there were 75,864,122 women in the United States according to the government figures. Of this number, 400,000 were professional nurses, approximately 5%. One hundred seventy-three thousand of these nurses are members of the American Nurses' Association, approximately 44%. We must immediately recognize that there is a small number of men professional nurses included in the total nurse group, but this does not distort the portrayal of the utilization of women by a single profession. No wonder then, that nursing has been called the fifth industry in the United States.

Our territorial statistics reveal that there are 1,418 professional nurses registered in the area, with a total of 766 members in the Nurses' Association, Territory of Hawaii, approximately 54%. This dearth of numbers then, points out that 5% of women in the U. S. are nurses, that Hawaii is keeping in step with other state nurses' associations by enlisting a little more than 50% of its potential into the ranks of its nursing organization. We are reminded that we are a rather small component of the national set-up.

After years of exhaustive investigation and study, it appeared that organized nursing was top heavy with diverse associations to which the individual nurses might belong. Common sense seemed to demand that nurses build a strong parent organization and eliminate some of the so-called special interest group associations which had become national in scope through the years. These associations saw fit to dissolve and to integrate their programs into two national organizations. Thus, we have functioned for four years. In order to stimulate participation by the various groups, the section plan was introduced by A.N.A. We now have seven sections.

Section activity is developing slowly. One of the stumbling blocks is the question of how we are to finance sections locally. Your Territorial organization must face this problem during the next few days. The idea that sections should be broken down into subunits and/or conference groups has gained impetus of late—chiefly to expedite a more active economic security program. The philosophy underlying this idea seems to be that small interest groups know what they have and what they want. However, isn't it true that when a pattern of this type is adopted, we are apt to examine the individual stone rather than the whole edifice? If we break down into smaller and smaller units because of introspective, sometimes mercenary, considerations, we are apt to lose our identity with a group in which lies our strength. Our membership is not so large that we cannot function as a strong body and still maintain our individuality.

Because a program is designed for the national use of 173,000 nurses, it does not follow that we must take the entire massive program to gear to a very small unit. Let us not have delusions of grandeur. Let us emphasize and reemphasize that we must be a closely integrated association, helping each other with section problems, not isolating groups into floundering nonentities. Let us examine our objectives in this association. We are organized that better nursing care will be available to the patient. Let us not forget the high ideals of our profession. By improving the status of nursing, we will improve the status of nurses.

May I express at this time my deep gratitude to each of you for allowing me to serve as your President for the past two years. It has been a great privilege.

(MRS.) ELIZABETH S. MCCALL, R.N.

NEW OFFICERS

NATH

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Second Vice President.....Mrs. Anne Camara
Treasurer.....Mrs. Helen Williams
Director-at-large.....Mrs. Elizabeth McCall
Maui Director.....Mrs. Marjorie Okinaka

Hawaii League for Nursing

Vice President.....Mrs. Hazel Kim
Secretary.....Genedina Bolosan
Director (Non-Nurse).....Brother James Wipfield
Dean Wilfred Holmes
Director (Nurse).....Sister Marie Therese

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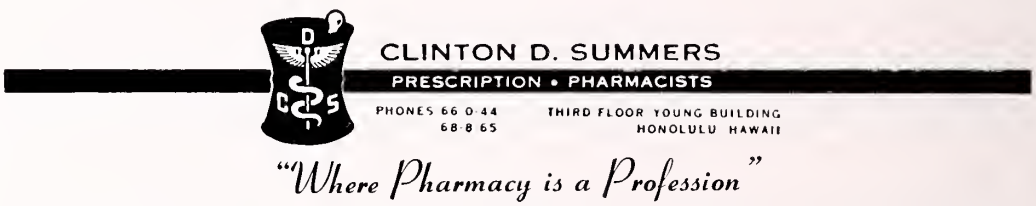
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Private Duty Section

Chairman.....Esther Higuchi
Vice Chairman.....Elvera Hamilton
Secretary.....Ermina Sandlos

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Chairman.....Winnifred Golley
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BOOK REVIEWS

(*Continued from Page 147*)

The Laboratory Diagnosis of Leptospirosis.

By J. W. Wolff, M.D., 99 pp., Price $3.75, Charles C. Thomas, 1954.

A valuable reference work on this subject by the Professor of Tropical Hygiene, and bacteriologist, of the Royal Tropical Institute in Amsterdam.

Protozoology.

By Richard R. Kudo, D.Sc., Fourth Edition, 966 pp., illustrated, Price $10.75, Charles C. Thomas, 1954.

Kudos to Kudo for this beautiful fourth edition of an authoritative reference work with outstanding illustrations. Primarily for teaching or research biologists.

Muscular Contraction.

By M. Dubuisson, Ph.D., 243 pp., illustrated, Price $6.50, Charles C. Thomas, 1954.

Exhaustive and highly technical analysis of the present state of our knowledge of this subject. He concludes we need to know more.

Of Publishing Scientific Papers.

By George E. Bruch, M.D., 40 pp., illustrated, Price $2.75, Grune & Stratton, Inc., 1954.

The author who is rather a perfectionist delivers some rather stinging rebukes to a lot of scientific writers identifying only by such expressive names as the self-plagiarist, the self-aggrandizer, the summary addict, the sensationalist and the miracle monger. It should be read by everyone who suffers even a slight form of itch to write.

The Physician and His Practice.

Edited by Joseph Garland, M.D., 270 pp., Price $5.00, Little, Brown and Company, 1954.

All about practicing medicine from its philosophy through group and specialty practice to medico-legal considerations and accounting practices. An ideal gift for any medical student or intern.

The Surgical Clinics of North America.

August, 1954—Thoracic Surgery and Neurological Surgery, pp. 873-1,198, figs. 223-299, $18 per clinic year, cloth binding, $15 per clinic year, paper binding, W. B. Saunders Company, 1954.

Symposia on thoracic surgery and neurological surgery.

Human Relations in Action.

By H. Edmund Bullis, A.B., M.E., and Cordelia W. Kelly, R.N., B.S., 86 pp., Price $1.50, G. P. Putnam's Sons, 1954.

Self-psychoanalysis in 86 paper bound pages, particularly useful to students.

Existence and Therapy.

By Ulrich Sonnemann, Ph.D., 372 pp., Price $5.00, Grune & Stratton, Inc., 1954.

This is just for psychiatrists.

Progress in Neurology and Psychiatry—Volume IX.

Edited by E. A. Spiegel, M.D., 632 pp., Price $10.00, Grune & Stratton, Inc., 1954.

A thorough up to the minute review of recent literature in the field of neurology, neurosurgery, psychiatry and the basic sciences relating thereto by 66 contributors.

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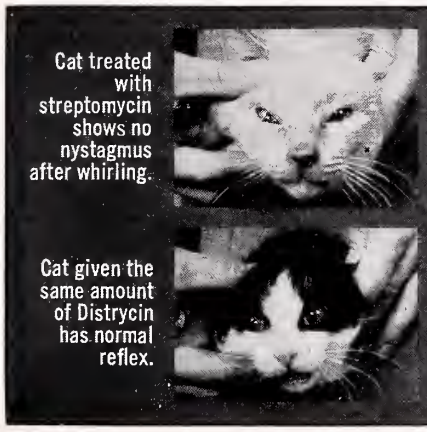
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	Cochlear damage % of patients		
	Mild	*Moderate*	*Total*
Streptomycin	0	0	0
Dihydrostreptomycin	12	3	15
Distrycin	0	0	0

**Heck, W.E.; Lynch, W.J., and Graves, H.L.: Acta oto-laryng. 43:416, 1953.*

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Wine in the Diet of Oldsters and Convalescents—There are sound, physiological reasons, therefore, why the generally lax and achlorhydric stomach of older people and convalescents reacts favorably to the mild, secretory stimulation of wine taken at mealtimes. And wine offers other valuable vasodilating, soothing, relaxing effects . . . a little Port or sherry wine at bedtime is a valuable aid to normal sleep, and may obviate the need for sedative medication.

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*Research information on wine is available upon request.

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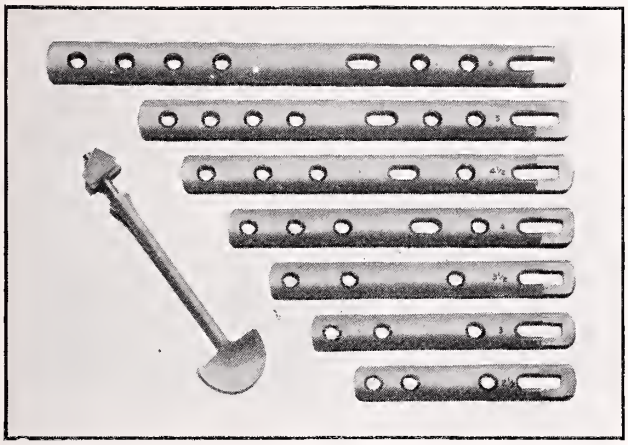
1. Malleson, J.: Lancet 2:158 (July 25) 1953. 2. Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc. 1953, p. 23.

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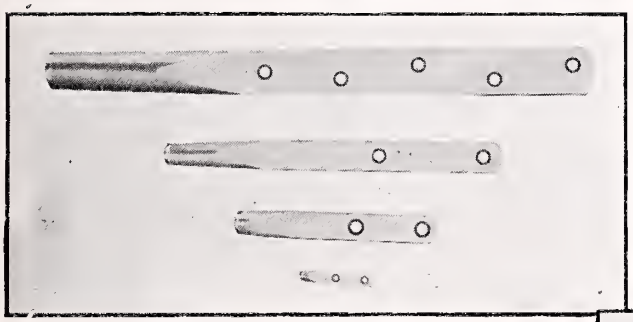


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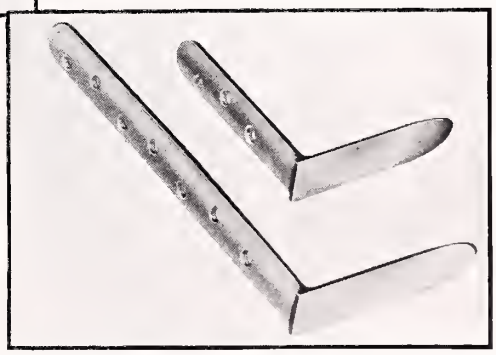
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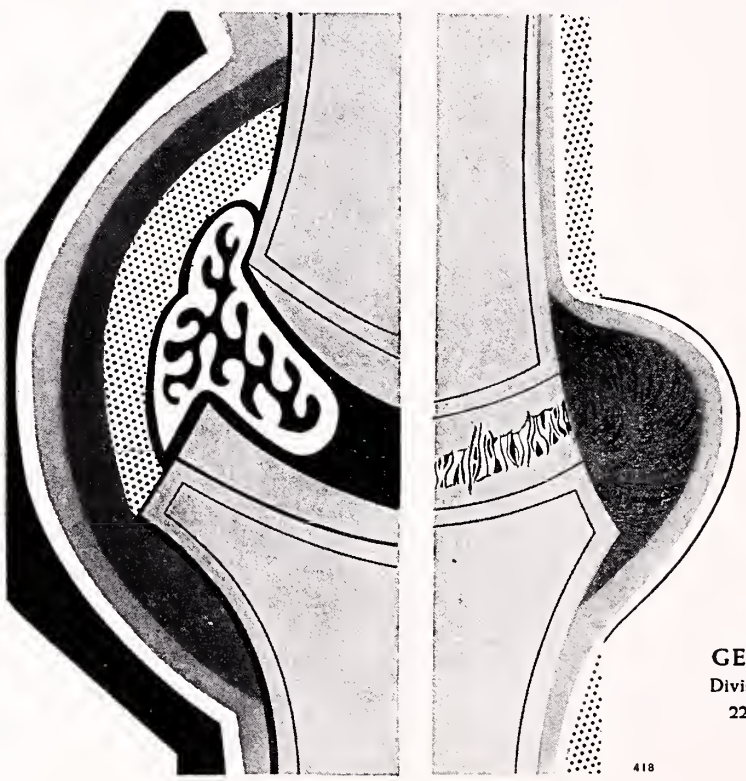
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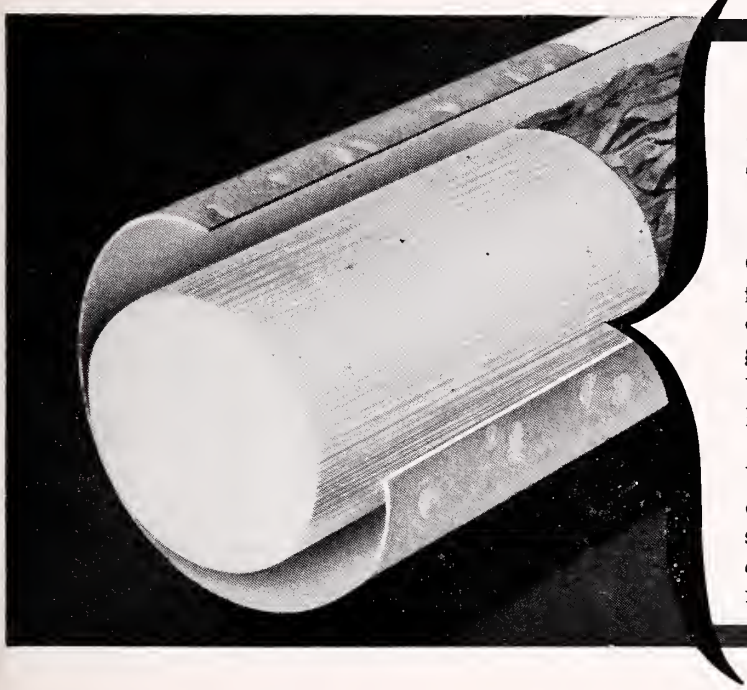
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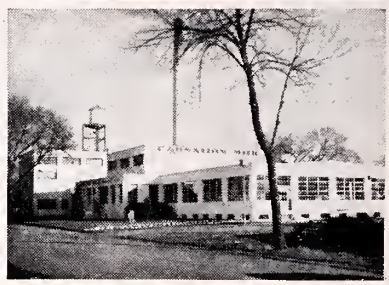
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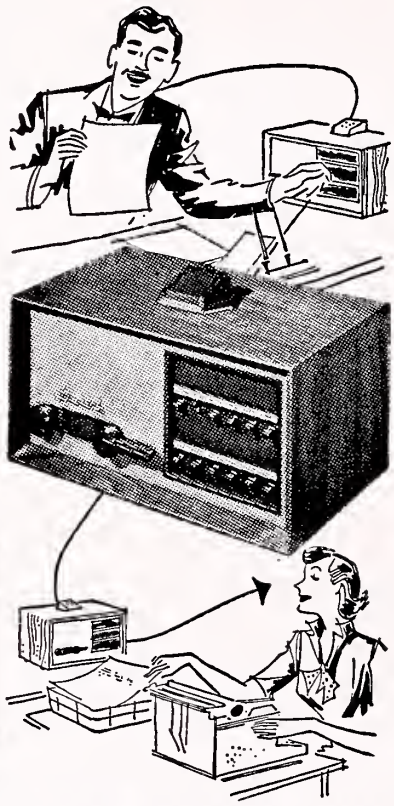
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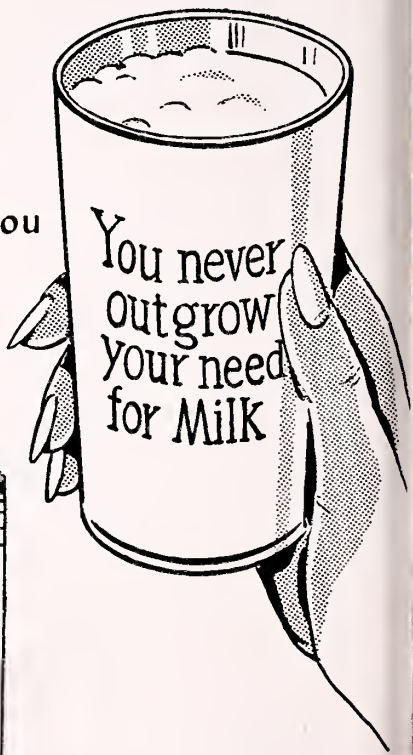
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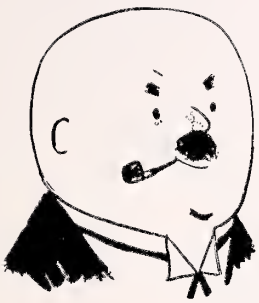
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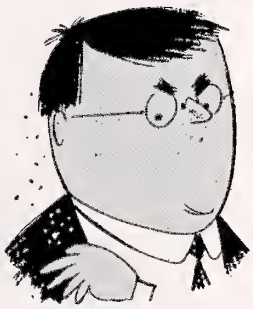
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*Straith, C. L., and Straith, R. E.: Detroit, Michigan. Postgrad. Med. *14*:165, Sept., 1953.





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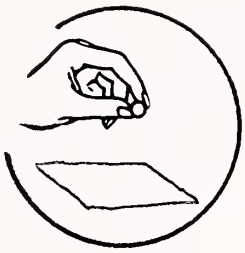
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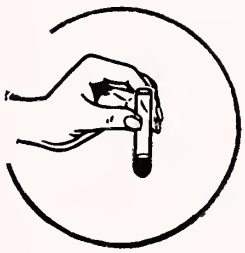
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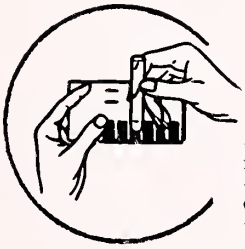
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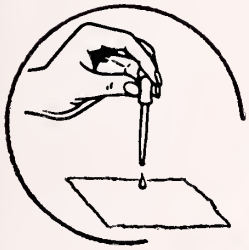
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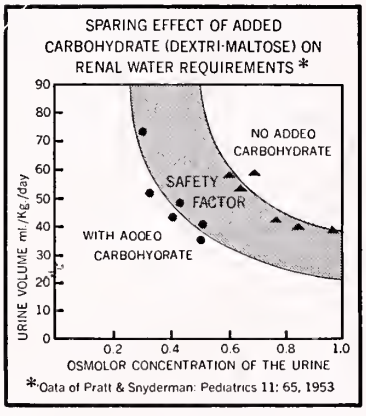
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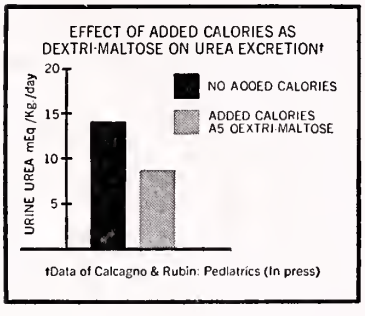
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1. Pratt & Snyderman: Pediatrics 11: 65, 1953; 2. Calcagno & Rubin: Pediatrics (in press); 3. Calcagno, Rubin & Weintraub: J. Clin. Investigation 33: 91, 1954; 4. Caake, Pratt & Darrow: Yale J. Biol. & Med. 22: 227, 1950; 5. Gamble: J. Pediat. 30: 488, 1947; 6. Rappaport: Am. J. Dis. Child. 74: 682, 1947.

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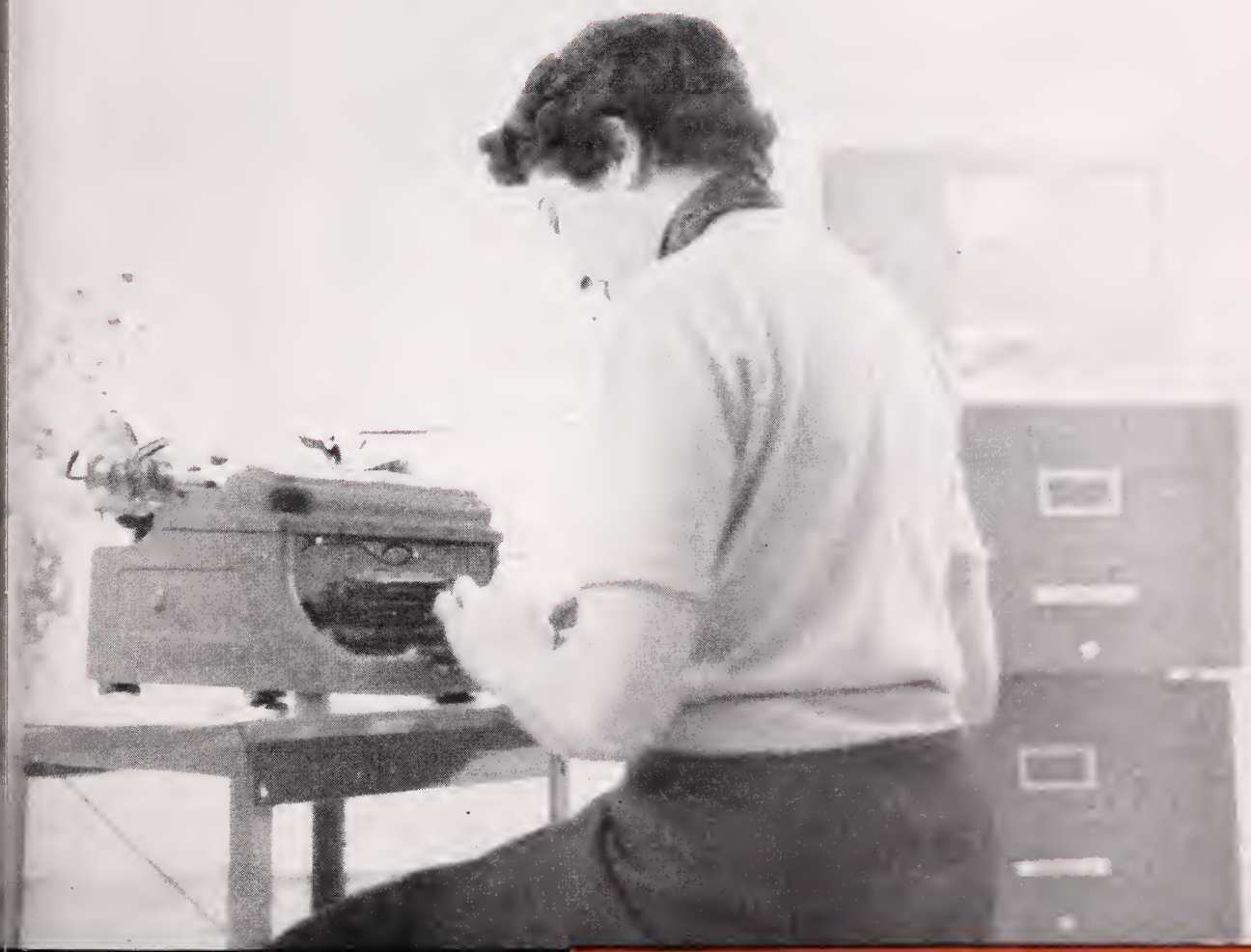
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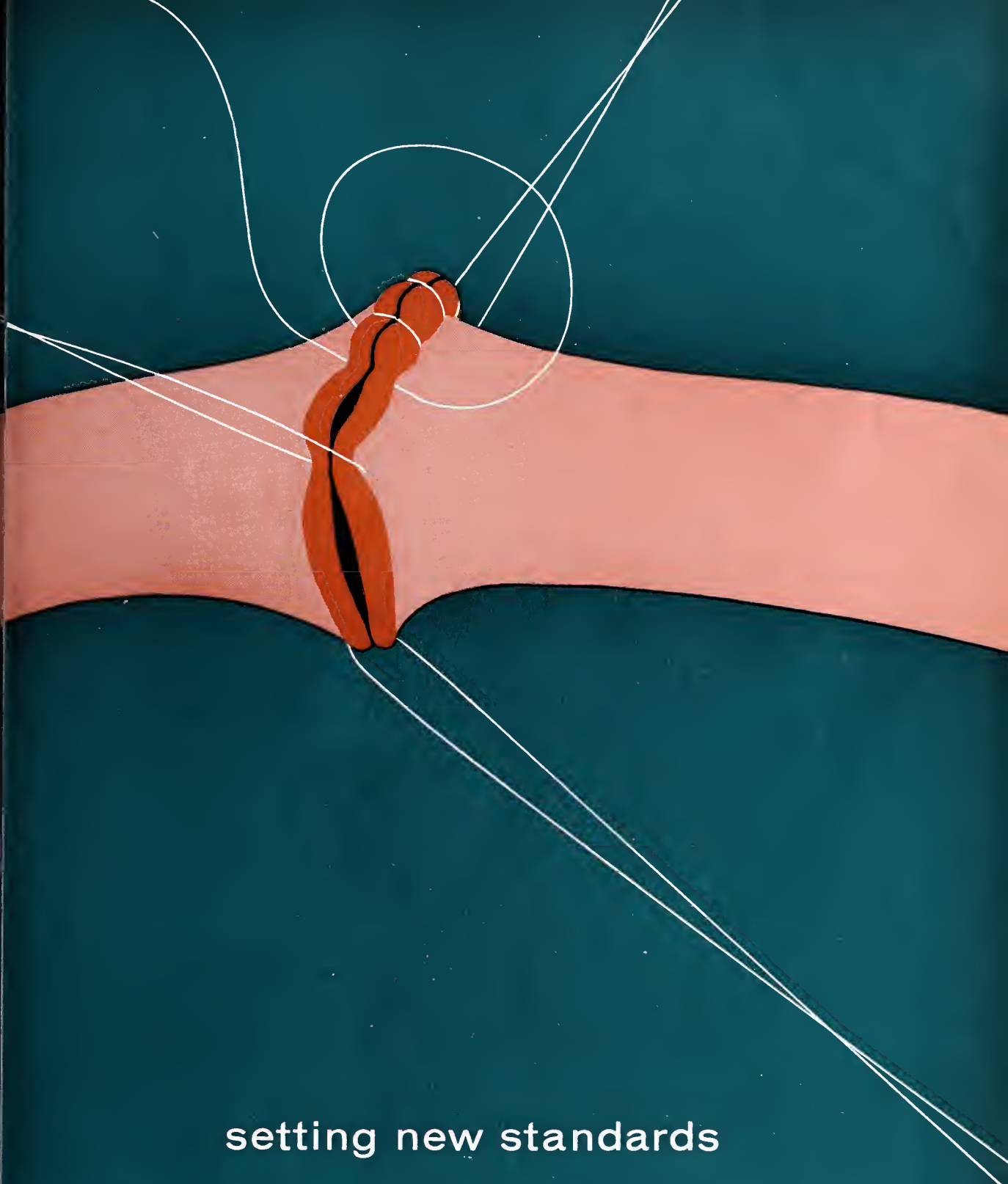
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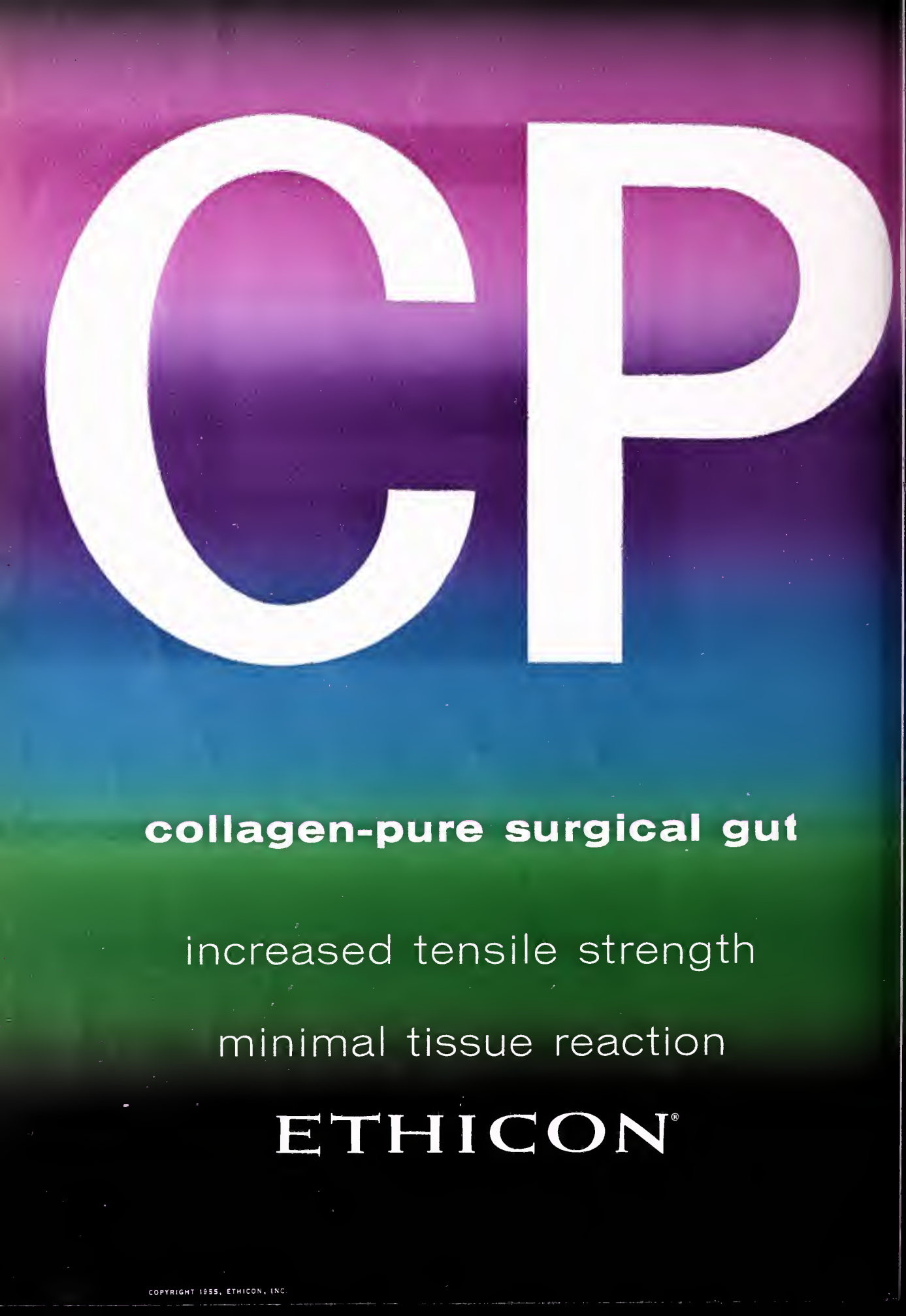
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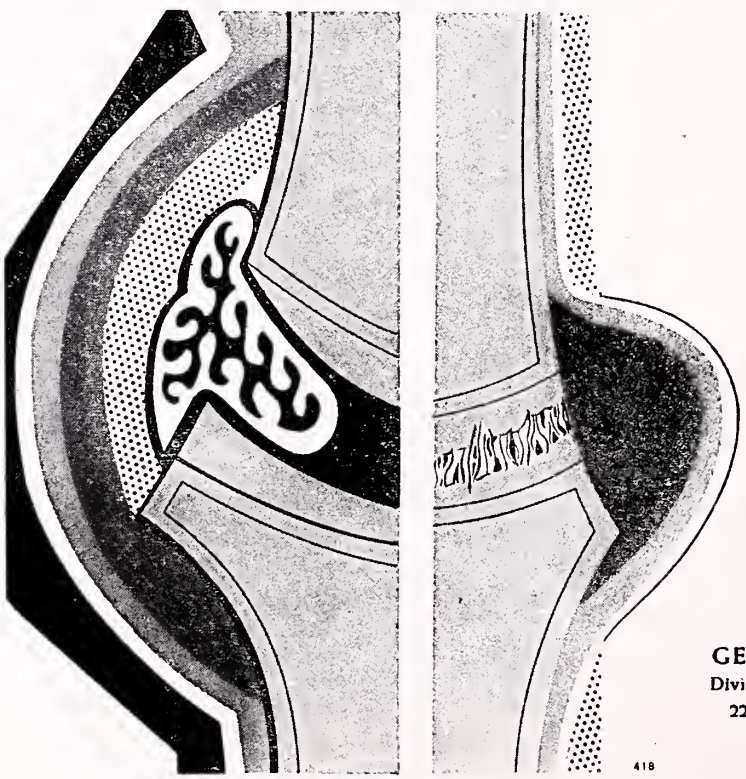
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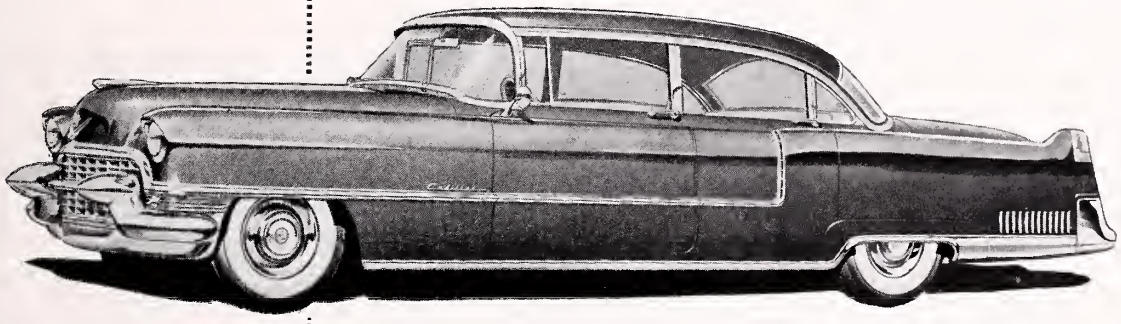
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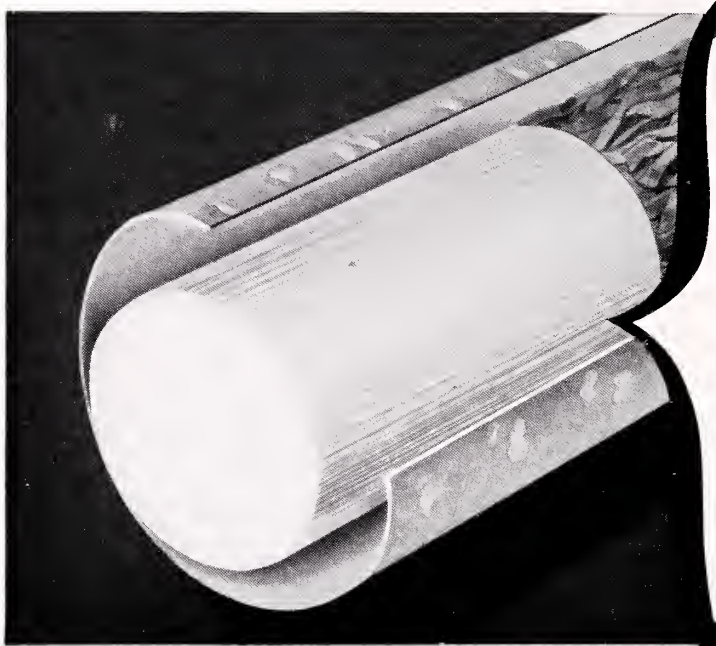
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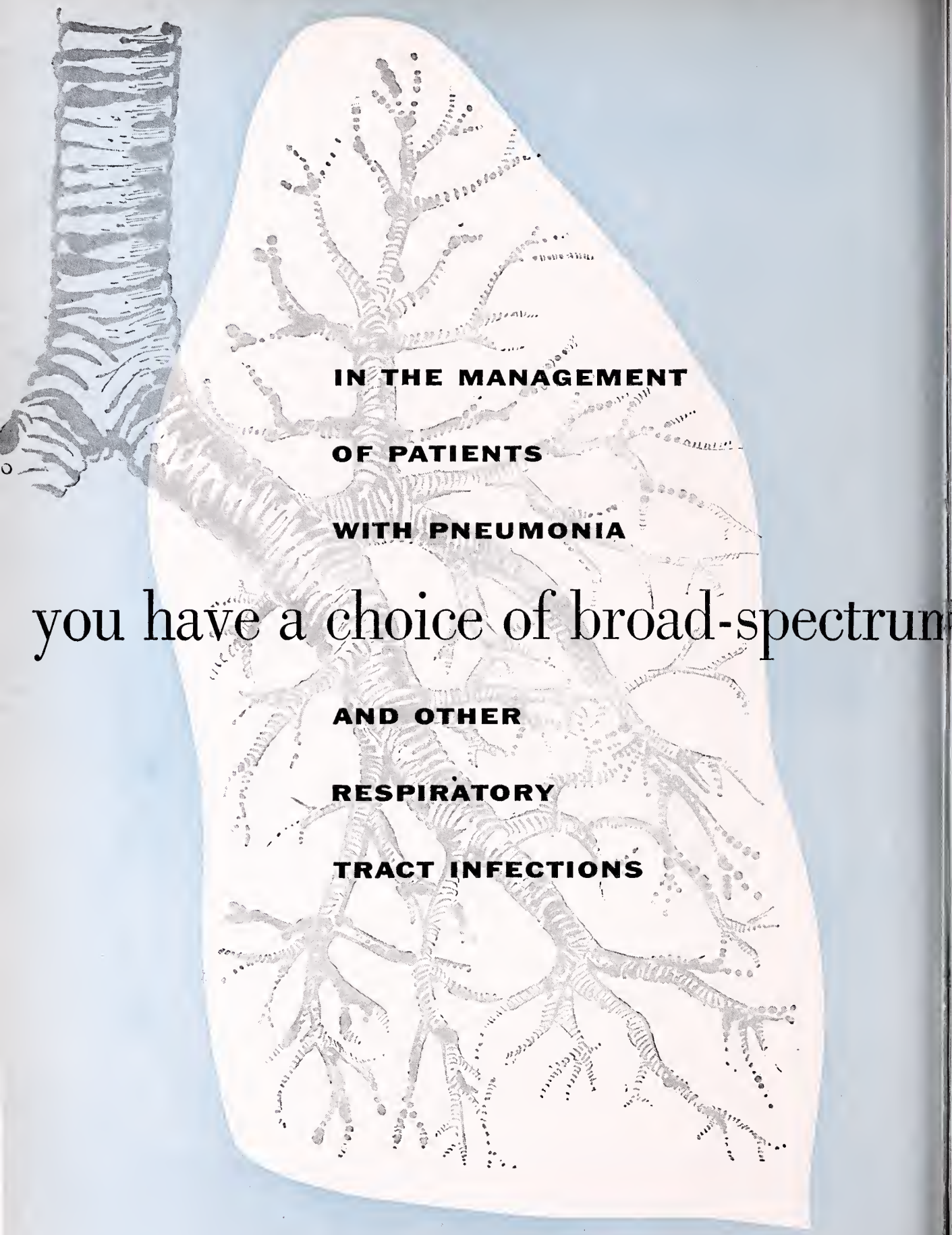
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1. *O'Regan, C., and Schwarzer, S.: J. Pediat. 44:172 (Feb.) 1954.*
2. *Waddington, W. S.; Bergy, G. G.; Nielsen, R. L., and Kirby, W. M. M.: Am. J. M. Sc. 228:164 (Aug.) 1954.*

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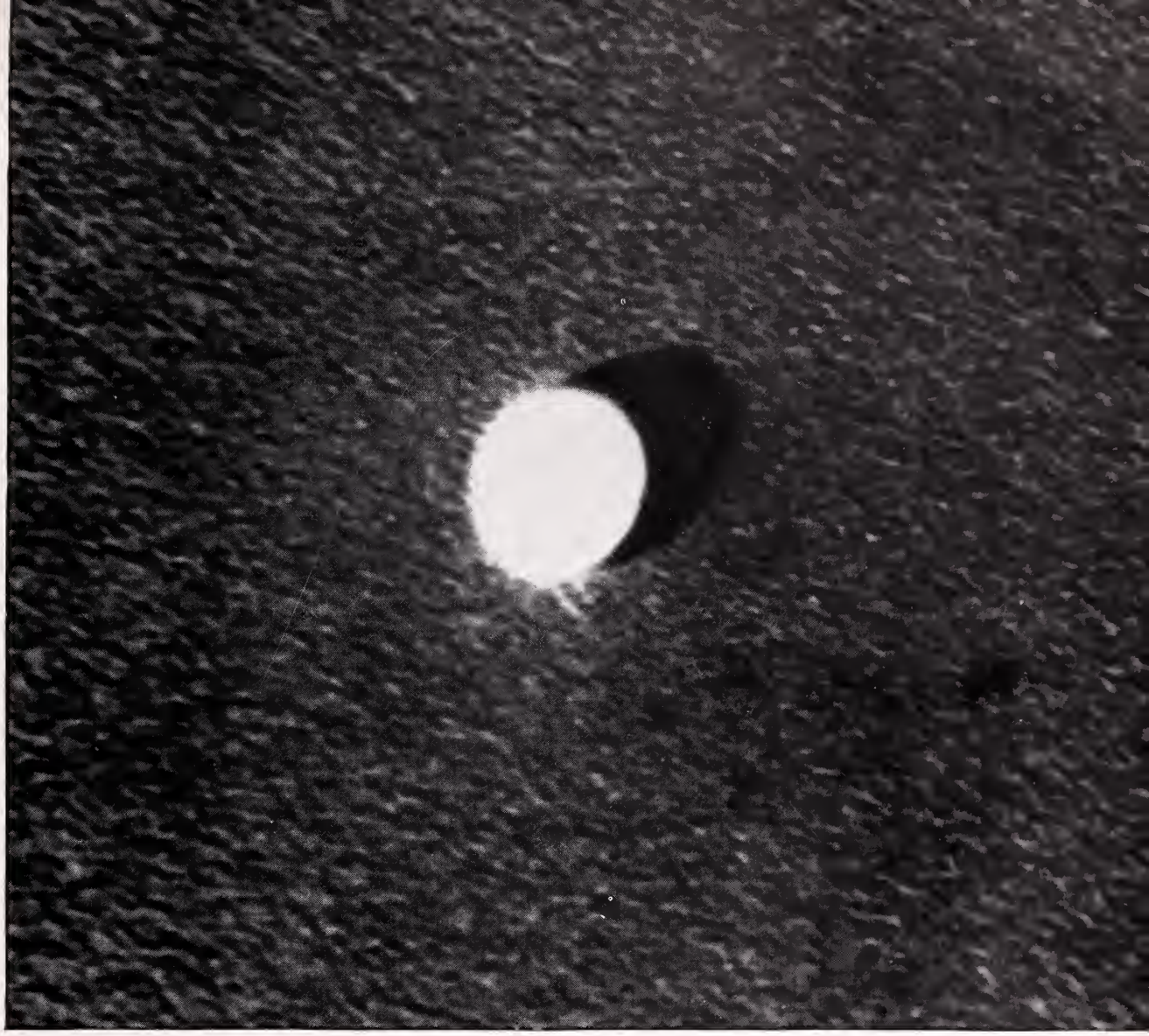
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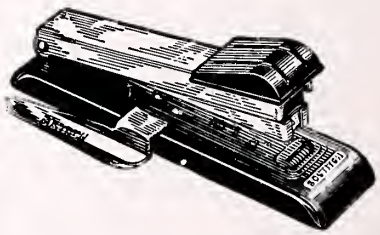
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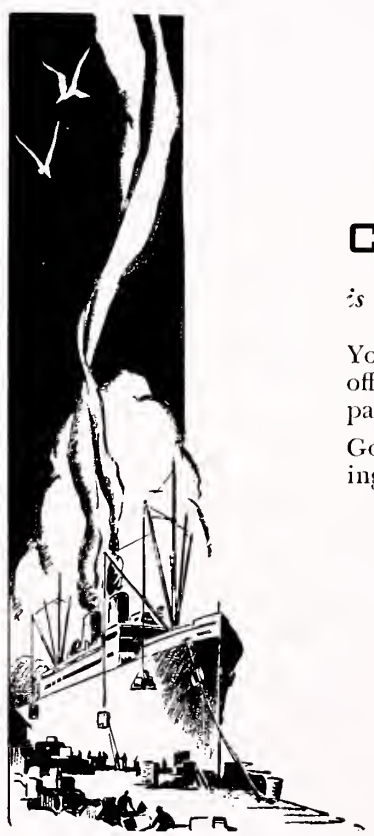


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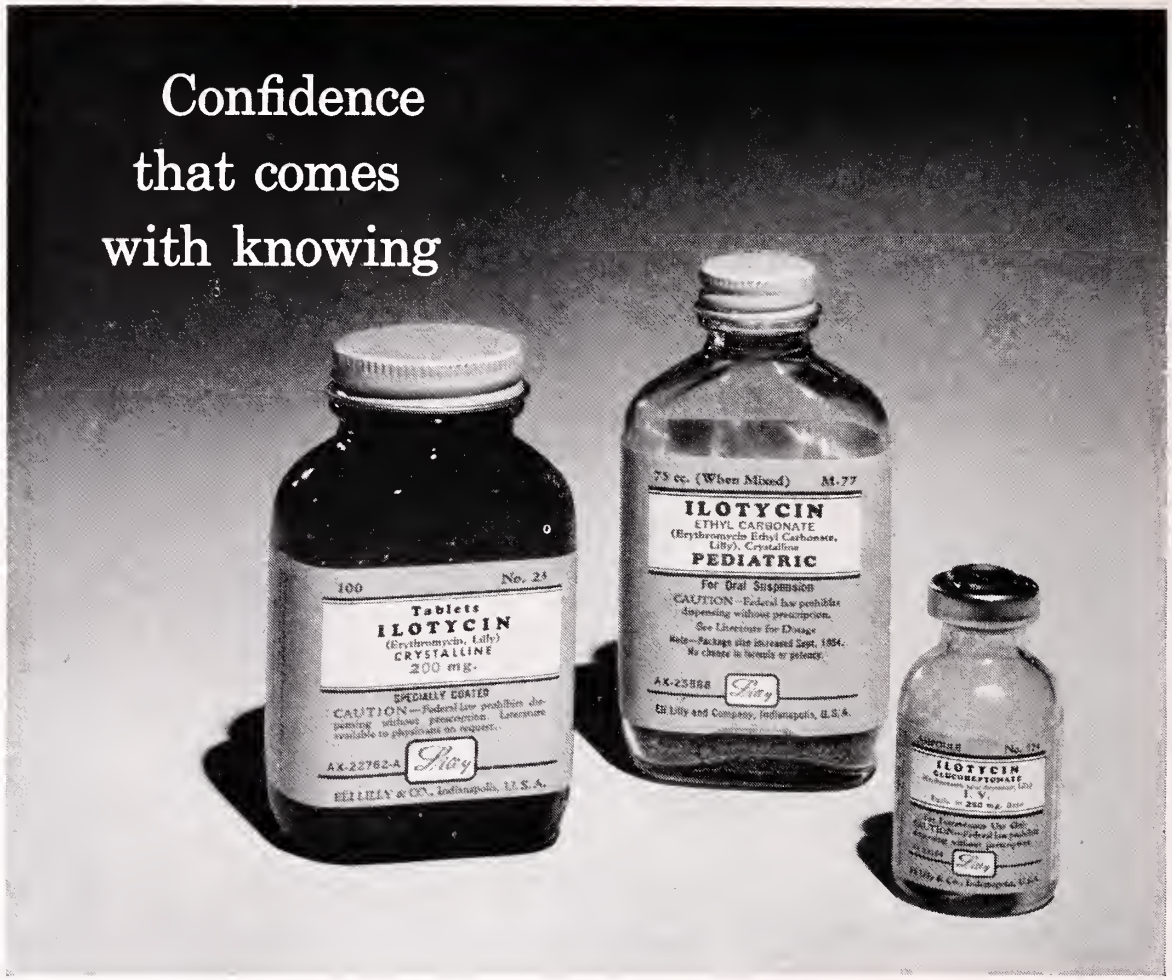


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SALMONELLA AND SALMONELLA INFECTIONS

II. Food Poisoning; Incidence of Salmonella and Antibiotic Coliform Bacteria

MAX LEVINE, Ph.D., JAMES R. ENRIGHT, M.D., KATHERINE J. EDGAR, M.D.,
GEORGE L. CHING, B.A., and RALPH H. TANIMOTO, M.S., Honolulu*

WHEN the senior author came to the islands, he asked about the incidence of salmonella infections and food poisoning and was informed that such occurrences were rare, if they existed at all. He has since become more convinced of the saying, "Seek, and thou shalt find." Our experience for the past five years indicates that salmonella infections (especially in young children) and food poisoning outbreaks are not rare but, on the contrary, altogether too common.



DR. LEVINE

Although infections due to salmonella, other than typhoid and paratyphoid A and B, were not reportable to the Health Department until about two years ago, the Health Department has been advised from time to time of the existence of such infections, as there is a close liaison with the local hospitals. Fecal specimens available to the Bureau of Laboratories of the Territorial Department of Health fall into the following three categories—(1) those submitted as required by law from individuals engaged in handling dairy products or who desire to visit, or must work on, the watersheds of the forest reserves; (2) hospitalized and other cases which are suspected of harboring salmonella or shigella; and (3) epidemiological follow-up of reported hospitalized or other cases, and positive laboratory findings associated with outbreaks of food poisoning which come to the attention of the Department of Health.

I. Food Poisonings and Their Etiologic Agents

The expression "You do not catch typhoid fever —you eat it," applies equally well to the paratyphoids, dysenteries and infections of the salmonella group. In addition, certain toxins elaborated by organisms may be ingested, resulting in symptoms of varying severity, although the organism itself may not be recovered. Formerly, most of the illnesses resulting from bacterial enteric pathogens (with the exception of the typhoids) were vaguely classified as "food poisoning" or "ptomaine poisoning."

Dack properly considers the term "ptomaine poisoning" as unscientific and meaningless. The term "ptomaine," derived from the Greek word "ptoma" meaning "corpse," was introduced in 1870 by the Italian toxicologist Selmi to designate amines obtained by ether extraction of the flesh of cadavers, which were found to be toxic on subcutaneous injection. It must be borne in mind, however, that substances toxic on injection are not necessarily poisonous when taken by mouth and that the actual occurrence of "ptomaine poisoning" is still to be proven.

On the other hand, the term "food poisoning" is not only vague but misleading. It tends to concentrate the attention on food proper and minimizes the importance of possible carriers as the source. It is no great triumph for an epidemiologist, with the help of a laboratory, to discover the same pathogenic organism in a food sample and in a patient; his work is not complete until the source *contaminating* or *infecting* the food is uncovered and eliminated. For this reason, the term "food-borne infections" is preferable for these enteric infections caused by the typhoids, bacillary dysenteries, and salmonellae. The illnesses caused by pre-formed toxins, such as elaborated by the botulinus and staphylococcus organisms, are preferably called "food-borne intoxications."

It is well to bear in mind that infected or toxin-containing food cannot ordinarily be detected by taste, smell, or appearance. The common putrefying bacteria and their products are not generally toxic. For example, Limburger cheese is a wholesome food (whether you like it or not) which contains putrefying bacteria and their products. Others like to hang game birds until, as Ilka Chase has it: "buzzards start flying up from the South." The ingestion of such "high" food does not cause sickness.

The following chart, modified from Dack, describes some of the orally acquired diseases which concern the Department of Health.

* Bureaus of Laboratories, Epidemiology, and Maternal and Child Health and Crippled Children; of the Territorial Department of Health, Honolulu, Hawaii.

This is the second of two parts, the first of which appeared in the preceding issue.

DISEASE	SPECIFIC AGENT	CHARACTER	SYMPTOMS	ONSET OF SYMPTOMS AFTER INGESTION
Botulism	Toxin-producing Clostridium botulinum	Intoxication	Difficulty in swallowing, double vision, difficulty in speech, difficulty in respiration, followed by death from respiratory paralysis.	2 hours to 8 days. Average 1-2 days.
Fish poisoning	Unknown	Intoxication	Nausea, vomiting, diarrhea. Flushing of face, numbness, tingling of mouth, hyperesthesia. Inversion of temperature sense is pathognomonic.	2-12 hours.
Staphylococcus food poisoning	Staphylococci which produce enterotoxin	Intoxication	Abrupt onset. Nausea, vomiting, diarrhea and acute prostration. Abdominal cramps.	1-6 hours. Average 2½-3 hours.
Streptococcus food poisoning	Alpha type	Infection	Nausea, vomiting, diarrhea, colicky pains. Prostration.	2-18 hours.
Shigellosis	Sh. Flexneri Sh. Sonnei Sh. Shiga etc.	Infection (Shiga-infection and intoxication)	Abrupt onset. Fever, bloody diarrhea, cramps, vomiting, prostration.	1-7 days.
Salmonellosis (Paratyphoid)	S. typhimurium S. anatum S. choleraesuis Over 250 other types	Infection	Abdominal pain, diarrhea, chills, fever, frequent vomiting.	7-72 hours.
Typhoid	S. typhi S. paratyphi (Para A)	Infection	Abrupt onset. Headache, chills, spiking temperature, constipation. Rash. Long convalescence.	3-40 days. Average 14 days.

Botulism, fortunately, has not been reported in Hawaii. It is included here to point out the similarity of the symptoms with those of alcoholic intoxication. Questioning, however, will reveal that the mind is clear in botulism poisoning. This is one condition in which it is well to have a respirator in readiness.

In staphylococcus or streptococcus "food poisoning," the onset is quite abrupt and, because of its short incubation period, many cases will occur at once if it follows a banquet, picnic or cafeteria meal. The principal offenders have been potato salad and sliced ham, as the organisms grow best with a salt content of about 3½%. Potato salad for an outing is usually prepared the evening before and, if refrigerated, is usually placed in a large container, rather than in shallow pans, so that while the surface may be chilled, the interior serves as a good culture medium. The enterotoxin of staphylococci, unlike the toxin of botulinus, is heat stable. Reheating gravies, ham, etc., will destroy the staphylococci but leave the toxin. Cultures of toxin bearing foods, therefore, may show no growth.

Cases of "food poisoning" should be reported by phone to the Department of Health. Tracing down the source is a joint operation of the Bureaus of Sanitary Engineering, Pure Food and Drugs, Laboratories, and Epidemiology. The overall direction and responsibility for the consolidated report rests with the Bureau of Epidemiology.

Reports of salmonellosis and shigellosis are received by the Bureau of Epidemiology from physicians, hospitals and laboratories. All positive reports of salmonella and shigella are relayed from the Laboratory to the Bureau of Epidemiology. The latter Bureau asks the private physician for permission to investigate the source of infection in the family. All contacts with positive laboratory findings are given notes of the findings and are instructed to see their private physicians. All food handlers with positive findings are advised to consult their private physicians and are immediately removed from work until their stools are negative for pathogens.

Fish poisoning, or ichthyotoxism, is considerably more prevalent here than on the mainland. The fish in the markets and those surrounding the Territory and in the North Pacific are safe.

Red snappers, black ulua and bass caught in the vicinity of Palmyra, Christmas and Easter Islands or, in general, any of the South Pacific Islands, may be poisonous at certain times of the year. For this reason, their sale in the Territory is forbidden. The outbreaks which have occurred in the Territory have been due to fish brought in by fishermen and given as presents to other families as well as eaten at home. An amusing example of this occurred sometime ago on a plane trip to Palmyra. A member of the Fish and Game division explained to all on board the danger of fish poisoning in certain Palmyra fish. He stated that if anyone chose to disregard his admonition, it

would be a good plan to feed some to a cat first. If the cat showed symptoms or died, the fish should not be eaten. This briefing was repeated as the party left Palmyra for Honolulu. In spite of these warnings, one of the party brought back some red snappers and gave part of his catch to a neighbor family. As soon as he heard that three in the family were hospitalized with fish poisoning, he hurriedly buried the remainder of the fish so his cat could not get it!

The outstanding symptoms of fish poisoning are a tingling or numbness of the mouth and lips often described as "pins and needles," or "a mouthful of nettles." Cold water gives a sensation of heat and hot foods seem cold. This is the only known condition that produces this temperature reversal. When you see someone blowing on his ice cream to "cool" it, you may state that the person is suffering from ichthyotoxism. Poisoning from the tetraodons, or puffer fish, is caused by an inherent toxin always present in part of the flesh and can be rapidly fatal. This is distinct from ichthyotoxism. These, however, are not considered as food fish and are not sold in the markets.

The last case of typhoid fever reported in Hawaii was in 1949. There are present on Oahu at this time only 5 known carriers, who are examined periodically and cannot act as food handlers outside of their immediate family.

The main point about typhoid is that it should be considered a blood disease rather than enteric, as the symptoms are produced by a blood stream infection and the organism may be found in the stool only late in the disease, or not at all. In this connection it should be emphasized that certain of the other salmonellae, especially Salmonella choleraesuis and Salmonella panama, are often invasive and can be detected by blood culture, while the non-motile shigellae seldom penetrate past the mesentery.

II. Incidence of Salmonella (Cases and Carriers) in Hawaii for the Period 1948-1952

The frequency of salmonella detection during the 5 year period 1948-1952 is indicated in Table 1.

TABLE 1.—*Incidence of Salmonellosis in Hawaii.*

YEAR	HOSP. CASES	EPIDEMIOLOGICAL FOLLOW-UP		GTHERS†	TOTAL
		M.C.§	*Carr.*		
1948	84	54	125	12	275
1949	21	25	35	12	93
1950	32	79	92	4	207
1951	23	18	12	18	71
1952	94	62	70	17	242
Total	254	238	334	63*	889
%	28.5	26.9	37.5	7.1	100.

* Includes 61 carriers and 2 missed cases.
† Dairy workers and individuals requesting watershed permits.
§ Missed cases.

It will be noted that during this period salmonella have been isolated from 889 individuals. Of these, 254 (28.5%) were hospitalized cases. A far greater number—572 (constituting 64.4% of isolations)—were detected by epidemiologic follow-up and examination of contacts: 238 missed cases and 334 carriers were detected in this manner. A few others, 61 carriers and 2 missed cases, were encountered in the course of routine examinations of stools submitted by individuals who desired to enter the watersheds or to engage in the dairy industry. Possibly a great many more would be unearthed if it were the practice to routinely examine all food-handlers in this way.

III. Distribution of Salmonella Among Various Age Groups

In Table 2 is shown the age distribution of individuals harboring salmonella. Of 889 isolations, cases comprised 494 individuals (254 hospitalized and 240 other cases) and 395 were from asymptomatic carriers. Because of the practice of vaccinating children at 3 years of age with typhoid, para A and para B (T.A.B. vaccine) the table has been arranged so as to show the distribution of salmonella among children 3 years old or less and the population over 3 years of age. It will be noted that, whereas the population of children 3 years of age or less is about 12.7% of the total population, 161 (or 32.5%) of the 494 cases fell into this age group. Considering the 254 hospitalized cases, 118 (46.5%) were among children 3 years of age, or younger, and 88 (34.7%) were among children less than 1 year old. Thus the case rate among unvaccinated children (3 years of age or less) is considerably greater than for the older, presumably vaccinated, population. The reverse is true with reference to the problem of carriers.

This raises the question as to whether vaccination with T.A.B. influences susceptibility to in-

TABLE 2.—*Age Distribution of Individuals Harboring Salmonella (1948-1952).*

AGE GROUP	CASES				TOTAL CASES AND CARRIERS	
	Hospital		*Others*			
	No.	*%*	*No.*	*%*	*No.*	*%*
6 mos.	45	17.8	10	4.2	55	6.2
6-12 mos.	43	16.9	11	4.6	56	6.3
1-3 years	30	11.8	22	9.2	70	7.9
3-10 years	14	5.5	15	6.3	61	6.8
10-20 years	4	1.6	7	2.9	39	4.4
20 years	118	46.5	175	72.8	608	68.4
<3 years	118	46.5	43	18.0	181	20.8
>3 years	136	53.5	197	82.0	708	79.2
All Ages	254	.....	240	.....	889	.....

Population—12.7% under 3 years.
87.3% over 3 years.

fection with other salmonellae than those contained in the vaccine. If there is such an influence, one would expect that protection would be restricted to those organisms falling in the salmonella groups to which the typhoid, paratyphi A and paratyphi B bacilli have been allocated, namely, Groups A, B and D.

IV. On Possible Protection Against Some Salmonella Infections Associated with T.A.B. Vaccination

How salmonella typing may throw some light on the possible role of T.A.B. immunization as a protective measure against salmonella other than the specific organisms present in the vaccine is worthy of consideration.

In Table 3 is shown the antigenic structure of several organisms in salmonella groups A, B, C, D, and E.

TABLE 3.—*Antigenic Components of Some Salmonellae.*

SALMONELLA		SOMATIC "O"	FLAGELLAR "H"	ANTIGENS IN
Group	*Type*	ANTIGENS	ANTIGENS	T.A.B.
A	Paratyphi (Para A)	(I), II, XII	a; - - - -	X
B	schottmuelleri (Para B)	(I), IV, V, XII	b; 1, 2	X
	typhimurium	(I), IV, V, XII	i; 1, 2	
C	montevideo	VI, VII	g, m, s; - -	
	oranienburg	VI, VII	m, t; - - -	
D	typhi	IX, XII, (Vi)	d; - - - -	X
	panama	I, IX, XII	l, v; 1, 5	
E	anatum	III, X, XXVI	e, h; 1, 6	

There is practically no paratyphoid A in the Territory (only one case was encountered in 5 years), and there are no other salmonella types in group A, so it will not be considered further.

It will be noted that Salmonella schottmuelleri (Para B) and Salmonella typhimurium (of group B) contain identical somatic "O" antigens (I, IV, V and XII) and several flagellar "H" antigens (1 and 2) in common, whereas none of the antigens of Salmonella montevideo and Salmonella oranienburg (which are in group C) are shared in common with Para B. One might, therefore, anticipate that immunization with Salmonella paratyphi B might confer some protection against Salmonella typhimurium but not against the organisms in group C.

Similarly, immunization with the typhoid organism (Salmonella typhi) which has the somatic antigens IX and XII might be expected to confer some immunity against Salmonella panama which is in the same group (group D) and has the same somatic antigens but would not be expected to exert protective action against Salmonella montevideo and Salmonella oranienburg which are in group C. By the same reasoning no protective action would be anticipated against Salmonella anatum which is in group E and whose antigenic components (with the exception of flagellar antigen 1) are distinctly different from those present in the organisms constituting the T.A.B. vaccine.

Since in Hawaii, the entire population over 3 years of age is presumably vaccinated with T.A.B., a consideration of the attack rates due to salmonella of group A, B and D among children 3 years of age or younger and rates for the population over 3 years old, as compared with the attack rates for corresponding age groups due to other salmonella (groups C, E, F, etc.), might be of interest in conjunction with the problem of non-specific immunity conferred by T.A.B. vaccination.

In Table 4 are shown the incidence rates, per million population, for those harboring salmonella of groups A, B and D as compared with those harboring group C and other salmonella for the two age groups (3 years or less and over 3 years of age). The case rates per million population for the respective age groups due to salmonella of groups A, B and D as compared to those due to other salmonella are also shown.

TABLE 4.—*Average Annual Salmonella Rates for Unvaccinated and Presumably T.A.B. Vaccinated Population (1948-1952).*

AGE GROUPS	RATE PER MILLION		
SALMONELLA GROUPS	*Under 3 Yrs.*	*Over 3 Yrs.**	
A + B + D	576	214	CASES AND CARRIERS
All Others	305	283	
A + B + D	514	102	FOR CASES ONLY
All Others	271	132	

* Presumably vaccinated with T.A.B.

The incidence of salmonella among unvaccinated children (3 years or less) was 576 per million population for salmonella groups A, B and D as compared with 214 for the population over 3 years of age, whereas the rates for those harboring other salmonella (group C and others) were practically identical, namely, 305 for the younger population and 283 for the population over 3 years of age. The incidence rate for salmonella groups A, B and D for children (under 3 years) was almost 3 times as high as that for the older population whereas for other salmonellae (those of C and other groups) the rates are almost identical for both age groups. The distribution of rates is such as might be expected if im-

munization with T.A.B. exerted a protective action against other salmonellae falling in groups A, B and D.

Considering the cases only, it will be noted that for nonvaccinated children (3 years of age or less) the rate for salmonella groups A, B and D was 514 as compared with 102 for the older, presumably vaccinated, population — or 5 times as high among the unvaccinated. In contrast to this, the case rates due to salmonellae in groups other than A, B and D were 271 for children 3 years old or less and 132 for the population over 3 years of age, or only about twice as high in the younger group. Possibly, at some future date, we may be able to get a complete vaccination history of each case and carrier of salmonella for more complete evaluation.

During the 5 year period, 1948-1952, 32 distinct salmonella types have been detected among 889 cases and carriers in Hawaii; but 7 salmonella types accounted for 691 (or 78%) of the 889 individuals harboring, and 390 (79%) of 494 active cases of salmonellosis. As three of these types are in groups B and D, against which the population over three years old is vaccinated, and the remaining 4 types are in groups against which vaccination has not been carried out, a comparison of the case rates for these 7 salmonella types among these 2 population groups is shown in Table 5.

TABLE 5.—*Average Annual (Hospitalized) Case Rates for Specific Salmonella Types in Unvaccinated and Presumably T.A.B. Vaccinated Population (1948-1952).*

SALMONELLA		NO. CASES ALL AGES	CASE RATES PER MILLION		RATIO $\frac{<3 \text{ YRS.}}{>3 \text{ YRS.}}$
Group	*Type*		*<3 Yrs.*	*>3 Yrs.*	
B	typhimurium	110	241	42	5.7
B	derby	34	72	14	5.1
D	panama	47	140	13	10.7
C	montevideo	83	44	52	0.9
C	oranienburg	24	24	13	1.9
C	birkenhead	31	29	18	1.6
E	anatum	61	54	35	1.5

For Salmonella typhimurium, the case rates were 241 per million for unvaccinated children (3 years or less) as compared with 42 for the population over 3 years, or 5.7 times as great for the younger unvaccinated age group.

Similarly, for Salmonella derby the respective rates were 72 and 14 and for Salmonella panama 140 and 13. The case rates were 5 times as high for Salmonella derby and almost 11 times as high for Salmonella panama among unvaccinated children (3 years of age or less) as for the rest of the presumably vaccinated population.

In contrast to this, it will be noted from Table 5 that for Salmonella montevideo (which is in group C for which there is no representative in the T.A.B. vaccine) the case rate is actually slightly higher among the older population group and, as regards the other salmonella types in groups C and E, the case rates among the young children (under 3 years) are only 2 times as high as among the older (over 3 years) age group. All of these figures seem to indicate that salmonella typing may throw some light on the value and the effect of T.A.B. vaccination against heterogenous intestinal pathogens of the salmonella group to which the T.A.B. strains are allocated.

It should be especially noted that among 47 cases due to Salmonella panama, 29 (62%) were among the unvaccinated children 3 years of age or younger, which constitute less than 13% of the population. The case rate was about 11 times as great for these unvaccinated children as for the older, presumably vaccinated, population. It is desired to call attention particularly to the fact that this organism seems to have very high invasive powers. During the year 1952, 3 cases of septicemia and 1 of meningitis due to Salmonella panama in children about 2 years of age or less, have come to our attention.

In brief, the experience with salmonella infections in Hawaii indicates that these organisms are far from being merely mild food poisoning agents of significance only to adults. They seem to constitute an important, and all too frequent, cause of severe enteric and systemic infections of young children.

V. Antibiosis Among Members of the Colon-Typhoid Group

A question which naturally poses itself is, why do not all individuals partaking of an infected meal or contaminated water come down with enteric disease? The answer has generally been, of course, that there are differences in the resistance of various individuals. This is undoubtedly true, but what is the nature of this resistance? Some evidence is developing to indicate that the antibiotic properties against enteric pathogens inherent in the normal intestinal flora of some individuals, which are lacking in others, or which are present in an individual at one time and not at another, might play a role.

A. *Observations with Fecal Coliform Strains*

The following photograph illustrates antibiotic action by certain coliform bacteria against another of that group.

A brief description of the technique employed might elucidate the significance of the photograph.

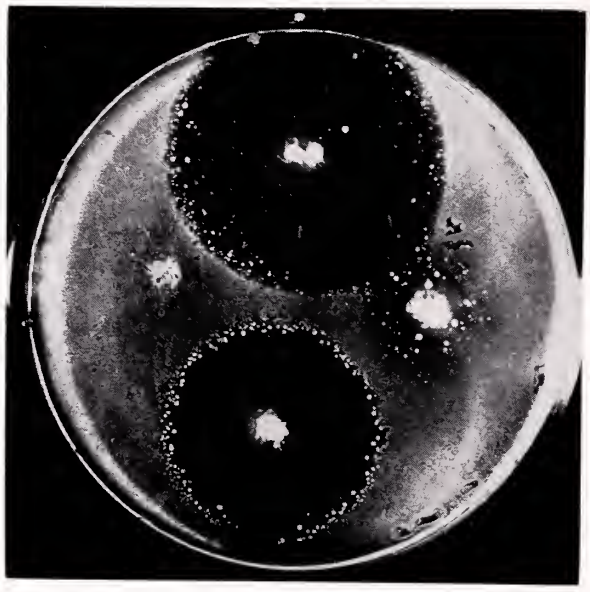


FIG. 1.—Showing antibiotic activity of coliform bacteria.

The agar medium in the example illustrated, was inoculated by stabbing at four different points with different coliform organisms. The medium was then incubated for 48 hours to provide an opportunity for each inoculum to develop into a colony and the products of growth to diffuse out into the medium. At the end of this time the organisms were killed by exposure, for about 2 hours, to chloroform vapor, which was then permitted to dissipate into the air. The entire surface of the agar was then inoculated with a broth culture of another coliform organism which was being examined for susceptibility to the four coli strains previously referred to. This inoculation is made by placing a piece of sterile filter paper on the surface of the agar and saturating it with a broth culture of the test organism, then removing the filter paper and placing the petri dish in the incubator overnight.

From the results, as indicated in the photograph, it will be noted that one of the coliform strains is so markedly antibiotic that the coliform strain being examined for susceptibility to antibiotic action was unable to grow within an area 50 mm. in diameter. Another was also strongly antibiotic, producing an inhibition zone about 40 mm. in diameter. A third was only slightly antibiotic and the fourth strain was not antibiotic at all against the test organism. The antibiotic substances produced by the coliform group of bacteria are referred to as "colicines."

B. *Observations on Susceptibility of Enteric Bacteria to "Colicines"*

In Table 6 are shown the antibiotic properties of a culture of Escherichia coli (strain #37) against various other enteric bacteria, as reported by the senior author in 1947.

It will be noted that this particular strain was antibiotic against 48 (85%) of 56 other escherichia strains that were studied. It is particularly noteworthy that it was antibiotic against 9 (27%) of 33 salmonella strains, and 31 (75%) of 41 shigella strains. In some instances, the zones of inhibition were very marked; thus, in 3 (or 9%) of the salmonella strains tested, inhibition zones of 50 mm. or more were produced; and in 6 others (or 18% of the salmonella strains examined), inhibition zones of 30 to 49 mm. were observed.

During the past few years we have, from time to time, tried to follow-up this phenomenon of antibiotic properties of some coliform bacteria and we have encountered such antibiotic strains on numerous occasions. The results obtained with two strains (H-10 and H-23) are particularly interesting and are summarized in Table 7.

Of 104 types of enteric pathogens of the salmonella and shigella groups examined, 101

TABLE 6.—*Per Cent of Various Enteric Bacteria Inhibited Antibiotically by Escherichia Strain #37.*

Diameter of Inhibition Zone		10-29 MM	30-40 MM	50+ MM	TEST STRAINS INHIBITED	
TEST STRAINS		*Per Cent of Strains Showing Various Growth-Inhibition Zones*				
*Group or Genus**	*No.*				*No.*	*%*
Escherichia	56	30	55	....	48	85
Paracolon	23	34	36	....	16	70
Citrobacter	13	38	47	....	11	85
Aerobacter	14	....	....	....	0	0
Proteus	7	....	....	....	0	0
Salmonella	33	....	18	9	9	27
Eberthella	6	83	17	....	6	100
Shigella	41	61	14	....	31	75
Total	193				121	63

* Generic terminology employed is that in vogue at time observations were reported in 1947.

TABLE 7.—*Antibiotic Properties of Coliform Strains H-10 and H-23.*

Group	SALMONELLA A	B	C	D	Misc.	SHIGELLA Flex.	Misc.	Total
	Number of Types Examined							
Antibiotic Coliform	1	8	14	38*	16	10	17	104
	Number of Types Susceptible to							
H-10	1	7	14	38	16	10	15	101
H-23	....	8	14	38	16	10	12	98

* Includes 23 typhoid stock phage types and 10 freshly isolated strains.

(97%) were found to be susceptible to coliform strain H-10 and 98 (94%) to coliform culture H-23.

C. *Observations with Coliform Strains from Throats of Infants*

Finally, attention is called to some observations on antibiotic properties of coliform strains isolated from the throats of infants up to 5 days old—a study which was made possible through the cooperation of the Bureaus of Maternal and Child Health and Crippled Children and the pediatric service of Tripler Army Hospital.

In the introductory remarks of this series of papers, it was intimated that the statement so frequently made—that coliform bacteria are not pathogenic as long as they remain restricted to the intestinal tract—was open to serious question. What we had reference to was recent reports in the literature to the effect that infant diarrheas (including many fatalities) have been attributed to specific serologic types of coliform bacteria, especially coliform serotypes O-55 and O-111. It has been definitely demonstrated, not only that these organisms were present in the stools of infected infants but that in a large proportion of instances they were also detected in their throats and the nasopharynx. Thus, Neter, in 1951, reported that these types of coliform bacteria were recovered from the upper respiratory tract of 11 out of 14 cases of infant diarrheas, and suggested that the organisms may be spread to other susceptible individuals in a manner analogous to that which occurs in air-borne infections.

With a view to obtaining, if possible, a norm for incidence of coliform strains in the throats of infants, and particularly to ascertaining whether any such strains encountered were of the pathogenic types—coliform serotypes O-55 and O-111—throat swabs from 232 infants at the Tripler Army Hospital nursery were examined. Coliform organisms were found in 40 (or 17.2%) of the throats examined and in 27 of these infants, members of the genus Escherichia were present.

A large number of strains (242) was examined to see whether any of them were of the pathogenic varieties, with entirely negative results. It was then thought that it might be interesting to observe whether these coliform strains, isolated from the infants' throats, possessed any antibiotic properties against pathogenic coliform types, salmonellae and shigellae, and 169 strains were examined for this purpose. Of these, 117 (69.2%) (obtained from 15 different infants) were found to be antibiotic; 99 (or 84.6%) of the antibiotic strains showing moderate antibiotic properties against Escherichia serotypes O-55 and 64 (54.7%) were found to be markedly antibiotic against pathogenic coliform serotype O-111. Furthermore, on testing 29 of the coliform strains against shigella and salmonella types, it was found that they were all antibiotic against the Shigella sonnei dysentery (Type I), which is by far the most frequent cause of bacillary dysentery in Hawaii among children between the ages of one and ten years but, perhaps significantly, rare among infants (under one year).

These observations on antibiotic properties of the common intestinal bacteria of the coliform group emphasize the importance of maintaining the normal flora in the intestinal tract. The results may possibly have a bearing on the indiscriminate and over-prolonged use of antibiotics which destroy the normal intestinal flora.

Summary

Salmonella infections appear to be far more common than is generally suspected; they are a frequent cause of food poisoning, and especially diarrheas in children, but are not restricted to intestinal disturbances.

Salmonella typing is important epidemiologically and may, at times, be of assistance to the clinician.

Examination of prospective mothers and personnel of maternity wards for salmonella, shigella and pathogenic coliform serotypes O-55 and O-111 might be a precautionary measure worthy of consideration.

Some of the normal intestinal coliform bacteria are antibiotic against salmonellae, shigellae and some pathogenic coliform strains. This antibiotic property may therefore play a role in protection against some of the enteric pathogens and constitutes a factor to be considered in the use of antibiotics which may destroy the normal intestinal flora.

Acknowledgment

The authors wish to acknowledge the efforts of Mr. Richard Onouye, Epidemiological Investigator of the Bureau of Epidemiology, whose diligence in collecting stool specimens from family and other contacts of known patients made this study feasible.

(Continued on Page 256)

THE HANSEN'S DISEASE PROGRAM IN HAWAII

An Open Letter to Senator Eva K. Bowring

RICHARD K. C. LEE, M.D.,* Honolulu

October 22, 1954

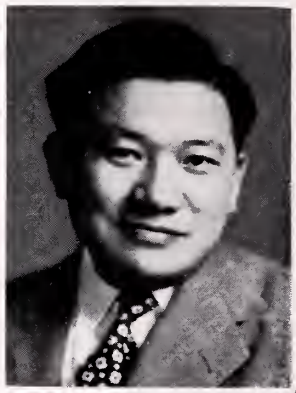
Senator Eva K. Bowring
Member, Committee on Labor
and Public Welfare
United States Senate
Washington, D. C.

Dear Senator Bowring:

It was a distinct pleasure and a privilege for me to have had the opportunity to tell you about our program for Hansen's disease in Hawaii and to show you through Hale Mohalu at Pearl City, Oahu, one of our two facilities for the treatment and care of persons with Hansen's disease. Your interest and concern with this public health problem in Hawaii is extremely heartening to those of us responsible for the administration of this activity. As I expressed to you in behalf of the staff and patients at Hale Mohalu, your personal desire to aid in the advancement of this program is most gratifying to us. As far as any of us can remember, you are the first member of Congress to visit any of the facilities of this program.

In response to your request for a statement of the objectives of the Board of Health and its needs in administering the Territory's program for the control of Hansen's disease and attendant care and treatment for those with the disease, I respectfully submit the following:

The Territory's program to care for its Hansen's disease patients was established in 1865. Since that time, Hawaii has expended millions of dollars for this program. Through the years some intermittent aid has been given by the Federal Government toward meeting the cost of the Hansen's disease program in our Territory. On March 3, 1905, by a decree of Congress, a leprosy investigation station was created, which began to function at Kalaupapa Settlement on the island of Molokai in 1909. This station, largely concerned with research work, was moved in 1914 to Kalihi Hospital in Honolulu, the predecessor of Hale Mohalu, and operated there under the jurisdiction of the United States Public Health Service and the Territorial government until June 13, 1942, at which time the research station was closed due to more pressing needs for the personnel in the war effort. With the termination of this station, the Territory received no further aid from the Federal Government until the enactment of Public Law 411 by the 82nd Congress. Under the terms of Public Law 411, Hawaii received a grant of $500,000 for fiscal year 1953, and $1,000,000 annually for fiscal years 1954 and 1955 to reimburse her for treatment and care provided the Hansen's disease patients of the Territory. The Surgeon General of the United States Public Health Service, who is charged with the responsibility to determine a proper per diem rate as the basis for reimbursement, excluded all capital expenditures in computing the rate because he felt this was not a proper charge under the present terms of the legislation. Moreover, the language used in Public Law 411 is such that reimbursement for this program is made subject to the availability of appropriations. Two things become immediately apparent under such an agreement: (1) There is no certainty from one year to another that an appropriation will be made by the Congress to reimburse the Territory, and (2) the amount of reimbursement which the Territory may expect to receive is not stabilized. Thus, while in recent years it has cost us approximately $1,100,000 annually to provide care and treatment for our patients, we were given reimbursement of only $500,000 for fiscal year 1953, $1,000,000 for fiscal year 1954, and another million dollars for the current fiscal year.



DR. LEE

Since 1917 the United States Public Health Service has maintained at Carville, Louisiana, a marine hospital for the care and treatment of persons with Hansen's disease. Any individual from any part of the United States who has been properly diagnosed as having this disease may be admitted to this National Leprosarium and receive care and treatment at the expense of the Federal Government.

Despite the availability of Carville, very few residents of the Territory of Hawaii have ever

* President, Hawaii Territorial Department of Health.

gone to that institution for treatment. Even since 1917, Hawaii has continued to maintain its own program for the treatment and care of persons with Hansen's disease. We have been asked why we don't just send all our patients to Carville and close our two institutions. Unfortunately for the Territory, the incidence of Hansen's disease is higher here than in any State. As of September 30, 1954 we have 458 registered cases. These include 252 active cases maintained in our treatment facilities, 77 inactive cases on temporary release for whom the Territory continues to provide domiciliary and medical care and 129 cases which we treat on an outpatient status. To our knowledge, Carville has a smaller roster than ours. If our patients are to be transferred to Carville, the Federal Government must first expend a large capital outlay for construction of additional facilities as well as provide for an increase to the staff of that institution. Then we must also consider the happiness and welfare of our patients. They would not have much opportunity to have their families and friends visit them if they are removed 4,500 miles from home. You will be interested to know that generally the people here do not have the fear of the disease which is prevalent elsewhere and much visiting goes on at our treatment facilities under prescribed isolation procedures.

In recent years the leprosarium in the Virgin Islands was closed and the patients there were transferred to Carville. We believe that Puerto Rico is also sending its Hansen's disease patients to Carville. Immigrants from Jamaica, Mexico, and other countries south of the border also add to the patient roster at Carville. In contrast to this, Hawaii's 458 patients consist of *376 U. S. Citizens,* 6 U. S. Nationals and only 76 aliens.

The trend of the disease in the Territory has been on the decline. In 1900 we had 2,000 patients in our sanatoria; today we have 329 actually under institutional care. The latter figure would have been lower if the Territory had not imported some 6,000 Filipino laborers in 1946. From that group, about 35 patients were admitted to our institutions. Then in 1952 about 1,800 Samoans migrated here and to date we have seven patients from that group admitted for care of Hansen's disease.

Despite the Federal aid which we are now receiving, Hawaii is spending in addition a $100,000 or more annually to provide care plus other sums when made available by the Territorial Legislature for capital improvements. Most of our structures are quite old and are in need of constant repairs and maintenance. It would be of tremendous help to us in furtherance of our program to attain the following objectives:

1. Full reimbursement to Hawaii by the Federal Government for care of Hansen's disease patients in the Territory's institutions based on our per diem rate experience. Our current per diem rate is $9.74 as contrasted to approximately $11.50 reported for Carville. According to our understanding, Carville's rate would be even higher if it were not for the fact that certain major maintenance cost is taken care of by separate appropriations by the Congress from time to time. While our current per diem rate is $9.74, we are currently allowed a rate of only $9.10 by the Surgeon General of the USPHS because certain items were excluded in his determination. The Territory should receive full reimbursement annually instead of being subject to the availability of appropriations as is the case at present.
2. Have the Congress of the United States transfer the title of the 11,223 acres of land at Waimano, Ewa, Oahu, which is the site of Hale Mohalu from the Government of the United States to the Territory of Hawaii. This land was originally acquired by the Navy for war use and several Wave barracks were constructed there. Since then, it is our understanding that the Navy has declared this property surplus to its needs. The Territory of Hawaii has used the land and buildings under terms of a revocable permit from 1946 to 1949 to provide domiciliary care for tuberculosis patients. Since 1949 this facility was converted to a hospital for the care and treatment of persons with Hansen's disease. In the period that this facility has been placed under our direct responsibility, we have done much to improve and to beautify it. However, the Legislature has been hesitant about appropriating money for additional capital improvements and for anything beyond more than minimal maintenance because we are occupying the site on a tenancy-at-will basis. The transfer of this property to the Territory is most necessary for our long-range program. I am sure that you can appreciate that under present circumstances we are in no position to develop any long-term planning for this program. The 1953 Legislature of the Territory passed a Concurrent Resolution to request the Congress of the United States to make this transfer but no action was taken by the Congress.
3. Do more research work in this field. We are preparing an application to the National Institute of Health for a grant to develop improved methods and procedures in the management of ocular leprosy. From time to time we intend to submit other project applications for nominal grants which would enable us to do research in this field. We have the facilities, material, and qualified personnel to do such research. Any new knowledge gained from such work will be made available to medical workers of all nations. It would be most gratifying to us to have the Congress of the United States include Hawaii in any appropriation it makes for research in the field of Hansen's disease.

I trust that you will forgive me for writing such a long dissertation on this subject, but I wish to provide you with an adequate background to understand our objectives and needs for this program. In administering the Hansen's disease pro-

gram, the Board of Health has concentrated on four program areas: (1) the early location and diagnosis of Hansen's disease patients in Hawaii and the provision of the best treatment known to modern medical science; (2) the continuance of a plan of segregation of patients while they are in an infectious stage in order to prevent the spread of the disease and to protect the public; (3) provision of recreation, education, and rehabilitation facilities to maintain good morale among patients and to prepare them to return to their home and community as useful citizens, and (4) an educational program for patients, patients' families, professional people, and the public in general of the facts regarding the disease.

We have received much commendation for the high standards of treatment and care which we provide and for our modern and humanitarian approach to the problem. These commendations have come from national and international leaders in public health and in the field of Hansen's disease administration. We look forward to maintaining our leadership in this field of medical knowledge.

We deeply appreciate the interest you have shown in our program and your expressed willingness to help us attain our objective. Achieving the objectives we have outlined here will be of immeasurable aid to us in attaining our ultimate goal of reducing this disease to the level where it can be treated in our regular hospital facilities.

Aloha and warmest personal regards to you. We hope you will find time to visit Hawaii again in the not too distant future.

RICHARD K. C. LEE, M.D.
President, Board of Health

ANATOMICAL CARDIAC STAMPS AVAILABLE TO PHYSICIANS AS RECORDING AID

Sets of anatomical cardiac rubber stamps are now available at cost to interested physicians to assist them in keeping records of heart patients. The rubber stamps were devised from diagrams in the book "Congenital Malformations of the Heart," by Dr. Helen Taussig, and published by the Harvard University Press for the Commonwealth Fund.

The stamps are distributed nationally by the Stamford Heart Association, 190 West Broad Street, Stamford, Connecticut, at a cost of $3.00 for each category (three stamps), postpaid.

The stamps imprint an outline of the heart and chest which enables physicians to record fluoroscopic findings of disease conditions or abnormal changes in the heart shadow. They are available in three categories. 1. *Infant:* small size, 1½" x 1¼"; large size, 2" x 1¾". 2. *Child:* small size, 1½" x 1¼", large size, 2" x 1¾". *Adult:* one size only, 2" x 1¾". Three views are available in each size, anterior, posterior, left anterior oblique and right anterior oblique.

OTOSCLEROSIS

Its Recognition and Treatment

JOHN P. FRAZER, M.D., Honolulu

THERE are two major classifications of hearing loss: conductive and perceptive. The conductive type is caused by obstruction to the vibration of the air waves either in the external canal, the drum, or the middle ear and ossicles down to the foot plate of the stapes. Deafness of this conductive type is frequently reversible, especially if early, adequate treatment is carried out. Examples are seen with impacted cerumen, abscess of the ear canal, perforations of the drum, or suppuration in the middle ear. Other examples are serous and catarrhal otitis media due to sudden barometric changes, as in aircraft descent. Similarly, allergic manifestations, or adenoids in children, may cause catarrhal middle ear changes with hearing loss of the conductive type. Otosclerosis also falls in this group because of the bony fixation of the ossicles.



DR. FRAZER

Perceptive deafness is also called nerve deafness and includes any dysfunction of the nerve pathway from the cochlear end organ through the hearing center. This deafness is currently regarded as permanent and irreversible. Examples of this type are the congenital deafness from maternal rubella in the first trimester of pregnancy; deafness following meningococcus or tuberculous meningitis; other degenerations of the eighth nerve occur in the acute exanthemata of childhood and in certain acute febrile illnesses. Protoplasmic poisons such as quinine and other drugs may cause permanent damage of the eighth nerve in all or part of its potential range. The recently rediscovered acoustic trauma previously called "boilermaker's deafness" is another example.

Etiology

The conductive type of deafness that we will discuss briefly is otosclerosis. This is a disease of unknown cause, approximately twice as common among women as in men, and always bilateral. Its onset is generally during the reproductive years from the teens through the forties. Symptoms, however, are often slow to reach clinical levels. Tinnitus and paracusis (ability to hear better in a noisy environment) are often present. About 50% of women afflicted with the disease notice an exacerbation or progression during pregnancy. The disease has a definite familial tendency, although it may skip several generations.

Pathogenesis is uncertain, and although many studies have been done concerning its relation to calcium and phosphorous metabolism, no correlation has been noted nor is it related to other diseases of bone. The typical pathologic lesion of otosclerosis is a bony overgrowth involving the stapes at its mobile attachment in the oval window. Such bony disease may occur without symptoms if it does not involve the stapes or other ossicles. These asymptomatic foci could only be diagnosed at postmortem, for it is only when such a focus causes fixation of the ossicular chain that we have clinical symptoms.

Diagnosis

In the early stages of this disease, there is no degeneration of the auditory nerve. Hence, since the ability to hear by air conduction is lessened but bone conduction is unaltered, there gradually develops a reversed or negative Rinne test. You recall that ordinarily we hear better by air than by bone conduction. In normals, a vibrating tuning fork can be heard by air at the auditory meatus after its vibrations have ceased to be heard through the temporal bone by bony transmission. In otosclerosis, the situation is reversed: a negative Rinne is present. Audiometric studies of a typical case reveal a flat curve hearing loss, that is, the loss is approximately the same in all frequencies. Most hearing loss is not noted until it exceeds 30 decibels. This is approximately the intensity at which human conversation is carried on, and people characteristically do not complain of deafness until it exceeds this threshold and they miss the spoken word of their colleagues.

It can be noted that the person with conductive deafness from whatever cause has a soft, well modulated speaking voice. This is because he hears the vibrations of his own voice well and consequently modulates his speaking and speaks in a low volume. On the contrary, a person with perceptive deafness often talks in a monotonous,

Read before the ninety-eighth annual meeting of the Hawaii Medical Association, Honolulu, May 13, 1954.



FIG. 1—Showing endaural incision.

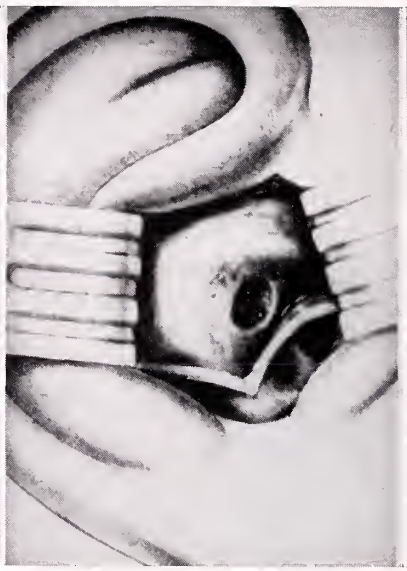


FIG. 2—Retracted incision, exposed cortex of mastoid, and first approach for exenteration of mastoid.



FIG. 3—Mastoid exenterated, semicircular canals exposed, cutaneous and osseous auditory canals visible.

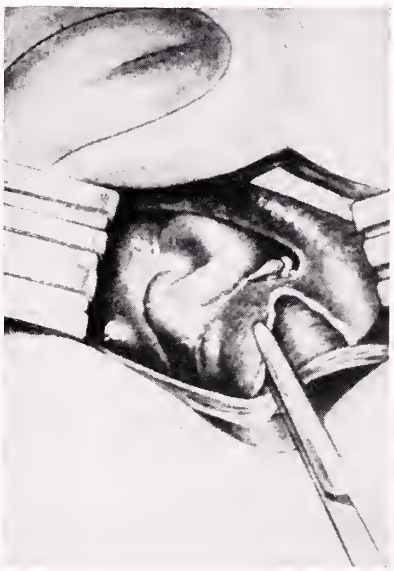


FIG. 4—Removing osseous auditory canal, showing further exposure in epitympanum to reveal head of malleus and the incus.



FIG. 5—Incus and head of malleus removed, fenestra created. Stapes, stapedius muscle, cutaneous canal wall and facial ridge are visible. This cutaneous wall will form the flap to cover the fenestra.



FIG. 6—Flap of cutaneous auditory canal, with tympanic membrane at its depth. Flap retracted posteriorly to cover fenestra.

sing-song manner. He does not hear his voice clearly and hence has no way of governing its inflection and accents.

Treatment

The treatment of some conductive hearing losses is done by many of you. Removal of cerumen, the treatment of the acute otitis medias, removal of adenoid and tonsil masses are all common therapies. The objective of all of these treatments is to allow the mechanical factors of the canal and the middle ear to operate in an optimum fashion. In any hearing loss, then, we attempt to make available sounds loud enough to stimulate the neural end organs of the cochlea above their threshold.

We can do this in two ways. The sound may be amplified with an electric hearing aid, or by having the speaker raise his voice above the patient's threshold of hearing. Also, if the auditory nerve is intact and a mechanical fixation is blocking transmission of the air waves or the ossicular movements, we may open a new route for the transmission of the vibrations. This can be done by short-circuiting the fused and fixed oval window in otosclerosis and creating a new window over the membranous labyrinth. This technique is called "fenestration."

The results of this technique are directly related to the integrity of the auditory nerve. In cases in which the nerve function is excellent, we can expect permanent useful hearing in 70 to 80% of fenestrated ears. If the nerve function is less, the results of permanent hearing for conversation may be as low as 60% of operated cases. Hence, the evaluation of the nerve function is of the utmost importance in deciding which cases are suitable for the surgery. The patient's psychic set-up is important in deciding if surgery should be done. Those who really want the surgery are good candidates; any who is questionable in his desire should be offered a hearing aid. We offer aids to all who can use them; if they reject them, they may be fit candidates for the surgery. A brochure is given to all possible candidates to explain their many questions and tell them of the postoperative sensations and course they may experience.

Conclusion

A brief discussion of the elementary aspects of conductive and perceptive deafness is given. A few high points of the clinical aspects of otosclerosis that should arouse suspicion of its presence are mentioned. Illustrations are given of the technique by which the stapes fixation of otosclerosis is short-circuited by the so-called fenestration of the labyrinth. Results to be expected are briefly listed.

1133 Punchbowl Street.

STUDY SHOWS ANTICOAGULANT DRUGS EFFECTIVE IN REDUCING DEATH RATE FROM HEART ATTACKS

Anticoagulant drugs are proving effective in reducing the death rate and complications among patients who have suffered a recent heart attack, according to the findings of the Committee on Anticoagulants appointed by the American Heart Association to conduct an extensive study of these drugs. The 680-page report of the Committee entitled, "Myocardial Infarction: A Study in 1,031 Cases; Its Clinical Manifestations and Treatment with Anticoagulants," has been published by Grune & Stratton, New York ($8.50). The authors are Drs. Irving S. Wright, Charles D. Marple, and Dorothy Fahs Beck.

OVARIAN TUMORS IN HONOLULU, HAWAII

Their Racial Frequency and Age Distribution

LIONEL McHENRY MAPP, M.D.,* Honolulu

HONOLULU has been described as "the crossroads of the Pacific." It is truly the meeting of the east with the west—a blending of nations into a living laboratory, suitable for the study of ethnic problems. Herein one finds "a melting pot of nations," living together as a harmonious whole. Hospitals here truly cater to patients, regardless of their color, creed, nationality or socio-economic status. It is this feature which has made the hospital population at St. Francis a good representative sample of the cross-section of the racial groups in Honolulu.



DR. MAPP

As early as 1899, Dr. Thomas R. Brown[1] of Johns Hopkins Hospital showed that the incidence of dermoids was comparatively higher in the negress than in the Caucasian female. Since then there has been much discussion as to the part played by race and environment in the etiology of ovarian tumors. Studies in this incidence, made in different areas by many capable men, have differed widely. This might have been due to:

1. The different methods used in the classification of the ovarian tumors.
2. The size and degree of pathology found in the tumors discussed.
3. Differences in the racial composition of the group wherein these cases were collected.

In this paper, cysts of less than 5 cm. in diameter are not always considered, as 5 cm. is the accepted limit of diagnostic palpability by the average gynecologist on bi-manual examination. Smaller cysts, incidentally found at operation and removed by the "ultra-conscientious" surgeon, often include such physiologic elements as simple follicle cysts and corpora lutea. For example, these normal elements accounted for 78.9% of a series presented by Carpenter[2] in 1936.

Tumors less than 5 cm. in diameter which are discussed in this paper are those which were diagnosed through their annoying symptomatology and found on pathologic examination either to be malignant, or to have a tendency towards future possible malignancy. Post mortem material is not included here.

Table 1 shows a breakdown of the actual numbers of the various types of tumors found among the people of the different races represented here in Honolulu. The groups which come under the classification as "others," include the Puerto Ricans, the Negroes, and the Koreans, who by themselves contributed such a small number of tumors, that their being considered separately would be of negligible value.

TABLE 1.—*Actual Numbers of Ovarian Tumors Found at St. Francis (January 1944 to August 1953).*

TYPES OF TUMORS	PATHOGENICITY	TOTAL NUMBER	FILIPINOS	CHINESE	JAPANESE	HAWAIIAN	PART-HAWAIIAN	CAUCASIAN	OTHERS
Dermoid	B	50	3	5	20	2	6	11	3
Serous Cystadenoma	B	70	4	5	10	2	8	34	7
Pseudomucinous Cystadenoma	B	24	1	4	5	1	6	6	1
Pseudomyxoma peritonei	B	2	....	....	....	1	....	1	....
Fibroma	B	9	....	2	....	1	1	4	1
Thecoma	B	1	....	1	....	....	....	....	....
Adenofibroma	B	1	....	....	....	....	....	....	1
Brenner	B	1	....	1	....	....	....	....	....
Parovarian	B	12	....	3	....	....	1	6	2
Carcinoma Primary	M	8	....	2	2	....	....	3	1
Carcinoma Secondary	M	4	....	2	1	....	1	....	....
Krukenberg	M	2	....	1	1	....	....	....	....
Adenocarcinoma	M	5	....	....	....	....	....	5	....
Pseudomucinous adenocarcinoma	M	2	....	1	1	....	....	....	....
Papillary cyst-adenomacarcinoma	M	6	....	2	1	....	1	2	....
Granulosa cell tumor	M	1	....	1	....	....	....	....	....
Malignant teratoma	M	1	....	....	....	....	....	....	....
Benign teratoma	B	1	....	....	....	....	....	1	....
Total malignant tumors	M	30	0	9	6	0	2	11	1
Total of all tumors		200	8	30	41	7	24	74	16

This table is of little value as a comparative study, however, because records available do not give a breakdown of the actual number of people in each racial group who were patients at this hospital during the time under consideration. It would also be of little validity to express these figures per racial unit of population, as there was a great racial shift in the population here, during and subsequent to World War II.

Of passing interest, however, we should note that the majority of parovarian cysts and all the

* Formerly Resident in Obstetrics, St. Francis Hospital, Honolulu, Hawaii.

Read before the ninety-eighth annual meeting of the Hawaii Medical Association, Honolulu, May 13, 1954.

[1] Brown, T. R.: Ovarian Cysts in the Negress, Bull. Johns Hopkins Hosp. 10:44 (Jan.-Mar.) 1899.

[2] Carpenter, C. C.: Tr. M. Soc. North Carolina, pp. 236-242, 1936.

adenocarcinomas were found among people of Caucasian origin.

Table 2 expresses the more numerous tumors of any type as a percentage of the total number of tumors found in any particular racial group. From this table it can easily be seen that:

1) The highest percentage of dermoids were found among the people of Japanese origin. This fact was previously noted by Omori and Skada[3] as early as 1890 and confirmed by Yamasaki[4] in 1911.
2) People with part-Hawaiian origin had a higher percentage of pseudomucinous cystadenoma than those individuals of purer racial origin.
3) The Caucasians showed a greater susceptibility to serous cystadenoma.
4) Malignant ovarian tumors were found to be more prevalent among the Chinese of Hawaii than among other people in this cosmopolitan community. Table 2 shows them to be about twice as frequent in this race as among the Japanese, the Caucasians and all the races combined.

TABLE 2.—*Percentage Racial Frequency of the More Numerous Ovarian Tumors at St. Francis (January 1944 to August 1953).*

TYPES OF TUMORS	PATHOGENICITY	ALL RACES	FILIPINOS	CHINESE	JAPANESE	HAWAIIAN	PART-HAWAIIAN	CAUCASIANS	OTHERS
Dermoid	B	25.0	37.5	16.66	48.8	28.6	25.0	14.85	18.75
Serous cystadenoma	B	35.0	50.0	16.66	24.4	28.6	33.3	45.9	43.75
Pseudomucinous cystadenoma	B	12.0	12.5	13.33	12.2	14.3	25.0	8.10	6.25
Total malignant tumors	M	14.5	0	29.7	14.6	0	8.3	14.9	6.25

The number of the other tumor types, and their percentage among the racial groups, is too small in this series to be of any statistical importance.

In 1942, Geist and Bernstein[5] presented a simple study of the age distribution of the various types of ovarian tumors. The age distribution of these tumors among people of the different racial groups will be presented here.

The fourth decade was the most common age for operation at St. Francis Hospital, on all patients with non-malignant ovarian tumors.

Dermoid cysts among the Japanese tended to cause annoying symptoms at an earlier age than among the Caucasians. In this series, the average age at operation for all patients with dermoids was 30.4 years, while among the Japanese this occurred earlier, at about 27.7 years. In the Caucasians, on the other hand, dermoid cases came to surgery at an average of 33.3 years of age.

TABLE 3.—*The Average Age of Occurrence of Certain Ovarian Tumors Among Certain Racial Groups in Honolulu.**

TYPES OF TUMORS	ALL RACES	CHINESE	JAPANESE	CAUCASIAN	PT. HAWAIIAN
Dermoids	30.4	.....	27.7	33.3	.....
Serous cystadenoma	32.4	.....	34.7	32.5	26.0
Pseudomucinous cystadenoma	39.7	34.4	43.8	39.7	38.5
Malignant ovarian neoplasms	49.0	51.3	41.1	57.2	.....

* Certain tumor types among certain racial groups were omitted because the actual number of these specific tumors found in that specific race in this series of tumors studied is too small to make its consideration valid.

The serous cystadenomata showed little variability in the age of occurrence among the various racial types studied. The average age at operation for all the patients with this type of tumor was 32.4 years. This was similar for the Caucasians whose average age was 32.5 years, while the Japanese averaged 34.7 years. People of mixed Hawaiian origin came to surgery for serous cysts of the ovary at an earlier age, averaging 26 years.

The pseudomucinous cystadenomata occurred with a more even distribution among the different ethnic groups. In the hospital population studied the average age of occurrence of this tumor was 39.7 years. This figure was approximately the same among the Caucasians, while among the part-Hawaiians the average age at the time of surgery for this tumor, was 34.4 years. The Chinese differed from the Japanese in this type of ovarian tumor. The former group showed symptoms requiring surgery late in the fourth decade, whereas the latter group came to operation about the middle of the fifth decade, when they were victims of pseudomucinous cystadenomata.

Summary

A series of 200 ovarian tumors found during surgery at St. Francis Hospital, Honolulu, Hawaii, has been presented. It is assumed that the hospital population here is a good representative sample of the racial distribution of the population in this cosmopolitan city.

Before concluding, however, it should be noted that a series of only 200 ovarian tumors is indeed too small for specific figures quoted to be completely or absolutely accepted as being the last word. Trends shown by this study, should be of assistance to the general practitioner or to the gynecologist in this environment, in the assess-

[3] Omori, H., and Skada, I.: Berl. klin. Wchnschr. 27:148, 1890.

[4] Yamasaki, M.: Beitrag zur Aetiologie der Ovarialdermoide und zur Kenntnis der darin vorkommenden Haare, Monatschr. f. Geburtsh. u. Gynäek 33:63, 1910.

[5] Geist, S. H.: Ovarian Tumors, Paul B. Hoeber, Inc., 1942.

ment of his case or cases before surgery and during surgery, should the guidance of a competent pathologist be unavailable at the time of operation.

116 S. 50th St., Philadelphia, Pa.

Discussion

DR. WALTER B. QUISENBERRY: I am very happy for the privilege of commenting on Dr. Mapp's report. He was kind enough to give me a copy several weeks ago. In these comments I will endeavor to compare the findings of Dr. Mapp with observations made from a study which Dr. Tilden and I have conducted of tumor cases admitted to hospitals in Hawaii during the period from 1944 through 1952. The project I refer to has been sponsored by the Hawaii Medical Association, the Hawaii Cancer Society, and the Territorial Health Department. In this study a total of 464 benign tumors and 3,257 malignant tumors have been included. Of the 464 benign tumors, 173 were ovarian in origin. Eighty-four malignant ovarian tumors have been included in the 3,257 cases mentioned above.

One difference between our study and that of Dr. Mapp is that we have included all tumors which were diagnosed as such by the attending physician regardless of size. Dr. Mapp has stated that cysts of less than 5 centimeters in diameter are usually not included.

The average age of women who have ovarian tumors in our analysis was 25 to 35 years. This is about the same as Dr. Mapp observed except in those who had mucous cystadenomas, where Dr. Mapp found the average age to be about 5 years more than the average age of our group.

Dr. Mapp found malignant ovarian tumors more frequent in Chinese women than in any other racial group. This was also true in our racial breakdown of 84 malignant ovarian tumors. However, we did not find that Chinese women had a rate 2 times that of Japanese and Caucasian women as Dr. Mapp found. Chinese women in our study have a rate 2 times that for all females combined.

Our findings on the racial frequency of dermoids agree quite closely with those of Dr. Mapp. We also found that Japanese women have dermoids much more frequently than do any other women in Hawaii. These figures seem especially significant since our findings and those of Dr. Mapp agree very well with the findings of Omori, Skada, and Yamasaki, as pointed out by Dr. Mapp.

Dr. Mapp found serous cystadenomata more frequent in Caucasian women than in any other racial group. This was not true in our study; in fact, we found no significant difference in the incidence of this type of ovarian tumor in the different races here in Hawaii.

It is noted that Dr. Mapp found mucinous cystadenomas most frequent in the part-Hawaiian women. I can make no significant statement regarding our findings in this matter because we had too few cases.

In summary I would like to again express my appreciation to Dr. Mapp for letting me see a copy of his report and for allowing me to comment on it. I feel that his report should make us think more about the significance of ovarian tumors in Hawaii. I am especially interested in the fact that he has found, as we have, that Chinese women have more than their share of the malignant ovarian tumors. This information, along with our own, may help in stimulating further study of this type of cancer. I am also interested in the fact that Dr. Mapp has pointed out, along with previous workers, that Japanese women have a higher frequency of dermoids than other racial groups. As I stated previously, this agrees with our findings. This too might help in bringing about further studies of this type of tumor.

DR. H. E. BOWLES: The title of this paper is self-descriptive, and as Dr. Mapp points out, Honolulu is a living laboratory in which to study ethnic problems of different racial groups. It is likewise a good laboratory for a study of disease incidence in these groups. In the mainland studies, very little material is available except in the negro and white groups; hence, Dr. Mapp's paper is particularly acceptable as another stepping stone in ethnic group studies in disease incidence.

The 5 cm. accepted limit for diagnostic palpability of ovarian tumors is a logical one. It is well known that many cystic tumors of smaller size are merely transient lodgers in the pelvis. While most ovarian tumors listed are few in number—and hence of not great statistical significance—the study is, so far as I know, the first of its kind in regard to ovarian tumor incidence in Hawaii.

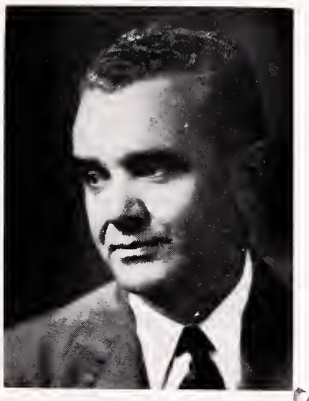
Of interest is the fact that the Japanese group shows the highest percentage of ovarian dermoid tumors and that they tend to cause annoying symptoms at an earlier age than among Caucasians. The reason is not clear and would not seem to be associated with earlier marriage in the Japanese group. In marriage age, there is little difference in one ethnic group from another. The number of rather late marriages in the Japanese group seems comparable to that of the Caucasian group. In Japan, it is an established fact that breast carcinoma is extremely rare in women; benign hypertrophy of the prostate is virtually unknown in Japanese males; while malignancies of the stomach and large bowel have a frighteningly high incidence.

Studies like Dr. Mapp's should be carried out more freely and his paper should serve as a stimulus to further work. The hospitals of Honolulu now have case records which permit such studies more readily than in the past. A few years ago, it was almost impossible due to poor clinical records and inaccurate diagnoses. Dr. Mapp is to be congratulated on an excellent piece of research which will be a valuable document for future reference.

FACE AND BROW PRESENTATIONS

H. McLEOD PATTERSON, M.D., and NATHAN SHKLOV, M.D., C.M., Honolulu

THIS paper reviews 22 face and brow presentations which occurred in 20,439 deliveries in the Kapiolani Maternity and Gynecological Hospital, Honolulu, Hawaii, from January 1948 to June 1953, inclusive. There were 19 face presentations or 1 to 1,075 and 3 brow presentations or 1 to 6,813. This is significantly lower than the incidence reported by Kenwick,[1] who summarizes several recently reported series showing that in 392,035 deliveries there was an incidence of face presentations of 1 to 556 and in 192,050 deliveries an incidence of brow presentations of 1 to 2,314. We believe that a brow presentation is usually a transition stage between full extension to a face or full flexion to a vertex and this fact probably accounts for the small numbers of brow presentations in this review. No doubt several original brow presentations when later classified had already become either a vertex or a face. Since the problem presented and the management given will be very much the same for both face and brow presentations, they will be considered together in this review.



DR. PATTERSON

Parity

It is interesting to note that 20 of the 22 patients were multiparas, giving us an incidence of 90.9% multiparas as contrasting with 62% in all deliveries. This gives us an even higher proportion of multiparas than was reported by Reinke[2] (65%), Kenwick[1] (66⅔%) or Groenig[3] (78%). These figures indicate that multiparity with its resultant loss of tone of uterine muscle, abdominal muscles and pelvic tissues is a major factor in the development of these troublesome presentations. However the two case reports in this paper are of young women each having had only one baby before, in both instances delivered by the senior author within the past 2 years. We do not feel that loss of tone of abdominal and pelvic tissues and structures was the cause of these abnormal presentations but rather the general build of the patients, each being very short.

Position

In our series out of a total of 22, 11 were mentum anterior, 5 mentum transverse and 3 mentum posterior, while there was 1 brow posterior, 1 brow anterior and 1 brow, unclassified.

Diagnosis

Recognition of the correct presentation early in labor was infrequent. Fifty percent were either undiagnosed as face or brow presentations, or were diagnosed as breeches, up to the time delivery was imminent. In several instances an incorrect diagnosis of a breech was made even after vaginal examination.

Certainly in every apparent breech presentation the possibility of a face or brow presentation should be considered. Abdominal palpation may give a clue in these abnormal presentations and rectal examination may make the examiner even more suspicious. A sterile vaginal examination should be done if the patient is in labor and the presentation in doubt and if then a face or brow is suspected, x-ray examination and pelvimetry should be done. X-ray findings are important. They may show an absolute indication for cesarean section or they may give information, especially if repeated during a trial of labor, which will prove the necessity of proceeding with cesarean section.

Length of Labor

In this series only 2 labors were prolonged—one for twenty-three hours and one for forty hours. Counting these two, the average length of labor was seven hours and thirty-six minutes. The labor of the longest duration (see case report 2), we consider to have been properly managed and to present many points which may prove helpful to others in the management of such problems.

Read before the staff meeting of the Kapiolani Maternity and Gynecological Hospital, October 22, 1953.

Received for publication May 25, 1954.

[1] Kenwick, A. N.: Face and Brow Presentations, Am. J. Obst. & Gynec. 66:67 (July) 1953.

[2] Reinke, T.: Face Presentation, Am. J. Obst. & Gynec. 66:1185 (Dec.) 1953.

[3] Groenig, D. C.: Face Presentation, Obst. & Gynec. 2:495 (Nov.) 1953.

Etiology

Several abnormal factors occurred in these pregnancies which we believe may have helped to cause extension of the fetal head and to have played a major part in causing these abnormal presentations. Cephalo-pelvic disproportion occurred 3 times, anencephalic monster with meningocele 1 time, polyhydramnios 1 time, ovarian cyst 1 time, and prematurity 2 times.

Method of Delivery

In our series 10 patients were delivered spontaneously, with all positions of the fetal head being represented except the brow. This is an instance of 45% of the total number of deliveries.

In 5 instances cesarean section was done, 3 being repeat sections. One section was done for cephalo-pelvic disproportion and one was done because of failure of the head to engage after an eight hour trial of labor in a primipara with a right mentum transverse position of fetus.

It was necessary to use mid-forceps in 2 instances. In the first of these the fetal head was rotated from right mentum transverse to right mentum anterior and a mid-forcep delivery was accomplished with great difficulty. The baby died twenty-four hours later. In the second instance the fetal head was manually rotated from right mentum posterior to right mentum anterior. Schatz and DeLee maneuvers failed to rotate the head to the left occiput posterior position. However finally it was rotated to the left occiput transverse position and Kielland mid-forceps applied. A normal baby was delivered. The mother sustained multiple vaginal lacerations and abrasions as well as multiple deep cervical lacerations and she suffered from urinary bladder atony which persisted for thirteen days after delivery.

In order to facilitate delivery, low forceps were applied in 4 instances. One was delivered from a right mentum anterior position and the second from a left mentum anterior position. The third was a brow which had spontaneously rotated to right mentum posterior position, at which time Schatz, Ziegenspek and DeLee maneuvers were employed with successful rotation from the right mentum posterior position to the left occiput anterior position, and then an easy low forceps delivery was readily accomplished. The fourth low forceps delivery was done by applying Tucker-McLean forceps to the head in the left mentum anterior position.

Complications of Delivery

Although several of the following complications occurred in the same patient, it was interesting to note that more than the usual number of complications did occur in these deliveries. Laceration of the cervix occurred in 2 instances; sulcus laceration occurred in 3 instances; a physiological contraction ring occurred in 1 instance; a retained placenta occurred in 2 instances; in one patient there was uterine atony immediately following delivery of the placenta, which was promptly controlled by the use of pitocin; excessive hemorrhage which required blood transfusion occurred in 3 patients.

Post-partum Complications

The following post-partum complications occurred: endometritis in 1 instance; subacute bronchitis in 1 instance and atony of the urinary bladder in 1 instance. In 14 of the 22 face and brow presentations there were no complications either at delivery or during the post-partum period.

There were no maternal deaths in this series. There were three neonatal deaths and one stillborn. The latter was an anencephalic fetus. Two of the neonatal deaths were very small, premature twins of six months gestation. The other neonatal death was a difficult mid-forceps delivery after manual rotation, the second stage being one hour and six minutes. It is interesting to note that in our series there was no neonatal death in those infants who delivered spontaneously or in those who were delivered by cesarian section.

Case Reports

CASE 1. Patient, age 25, para 1, gravida 2, was admitted to the hospital January 29, 1953, her expected date of confinement being January 27, 1953. General physical findings were normal. At 8 P.M. January 28, 1953 she began to have a sense of mild continuous sacral discomfort. This continued till 2:30 P.M. January 29, 1953 when she presented herself at the office. Rectal examination at that time revealed the presenting part to be engaged at station O. The cervix was 2 cm. dilated. It seemed that a face might be presenting and the patient was so advised. At 4 P.M. she started to develop three-minute contractions. She was hospitalized at 5 P.M. and rectal examination at that time reaffirmed the previous diagnosis of face presentation. Dilatation at this examination was thought to be 5 cm.

In order to confirm the diagnosis a vaginal examination was next performed using sterile technique. Diagnosis of face presentation was confirmed. The position was found to be right mentum posterior. The membranes were intact and dilatation was found to be complete. The membranes were then artificially ruptured. A very large amount of amniotic fluid was expelled at this time and repeatedly during subsequent maneuvers suggesting the definite presence of polyhydramnios. The chin was easily rotated to right mentum anterior. However, attempts to convert it to left occiput posterior by the Schatz, Thorn, and DeLee maneuvers were unsuccessful. Finally Kielland forceps were applied to the head which had been manually converted to left occiput transverse and it was delivered by midforceps onto the perineum fairly easily. The forceps were then removed

and head and baby were delivered in the usual manner. The total length of labor was four hours and five minutes. The patient sustained multiple cervical lacerations, laceration of the right vaginal wall and 750 cc. of blood loss which was replaced by 1000 cc. of whole blood. She also developed urinary bladder atony for thirteen days post delivery. The condition of the infant was good. The condition of the mother was excellent on date of discharge February 13, 1953.

CASE 2. This patient, age 23, para 1, gravida 2, was admitted to the hospital July 24, 1953 at 12:05 A.M., her expected date of confinement being July 23, 1953. On admission her general physical findings were normal. Membranes on admission were intact. Contractions had begun at 6:05 P.M. July 23, 1953. In view of a doubtful rectal diagnosis, a vaginal examination was performed at 5:30 A.M. The findings at this examination revealed a brow presentation at –1 station with the cervix dilated 5 cm. Membranes were intact. Immediately after this examination x-rays were taken and the following findings were reported:

> Examination of the abdomen, AP and lateral projections shows the presence of a single near term fetus in a vertex presentation. There is very marked hyperextension of the fetal skull. The brow is the presenting part. This is due to marked hyperextension of the skull and fetal cervical spine.
>
> The maternal pelvis appears adequate in this view but the presentation of the fetus may make spontaneous delivery either very difficult or impossible. The fetus otherwise appears normal.

At 9:00 A.M. the Schatz maneuver was attempted but was unsuccessful. The condition of the mother and the baby was good and it was decided to allow the patient to continue further labor. At 12:30 P.M. dilatation was found to be 8 cm. and station to be –1 and contractions were now becoming harder.

Repeated x-rays at 2:45 P.M. showed:

> Very marked hyperextension of the fetal skull and the fetal cervical spine. The brow is still the presenting part. The extension appears to be even more marked than it was at the last examination. It is doubtful if this baby could deliver in this present position.

The membranes were ruptured artificially at 5:30 P.M. and examination revealed the presenting part to be now right mentum posterior. Under deep ether anesthesia by the DeLee maneuver the head was rotated from right mentum posterior to left occiput anterior. A scultetus binder was applied to maintain the new position. The patient was allowed to come out of the anesthetic. Dicrysticin was started. The urine showed three plus acetone and 1000 cc. of 5% glucose in distilled water were given to combat this. For the next eleven hours patient had practically no uterine contractions and she was allowed to rest. X-rays then were reported as follows:

> Re-examination shows that there is considerably less extension of the fetal skull and neck. The head is now in a military attitude and is presenting at its longest diameter. Ordinarily, when head is in this position, the usual flexion occurs and with the size of the maternal pelvis, one would expect spontaneous delivery.

It was decided to stimulate uterine contractions by small amounts of intravenous pitocin (5 minims pitocin in 600 cc. of 5% glucose in distilled water at rate of 50 cc. per hour, the rate being slowed down if contractions were severe or prolonged). The physician was in constant attendance. Good uterine contractions were obtained and after four hours the pitocin solution was discontinued, the dilatation of cervix now being complete with the head at plus 2 station. Low spinal anesthetic was given and delivery of a normal male infant was easily accomplished by low forceps. Because of the forceps application the cervix was inspected and a 3 inch laceration, not bleeding, was found and sutured. The total labor had been forty hours. The mother and baby were discharged on the fourth post-partum day, each in excellent condition.

Summary and Conclusions

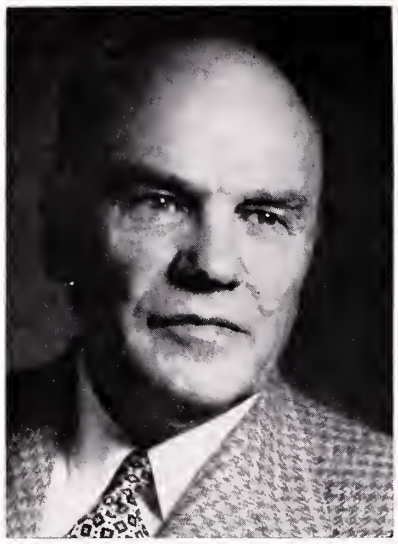
Twenty-two cases of face and brow presentations which occurred in 20,439 deliveries in the Kapiolani Maternity and Gynecological Hospital from January 1948 to June 1953 are reported. The majority were delivered vaginally. There were no maternal deaths but 3 fetal deaths occurred. Ninety and nine-tenths percent were multigravida.

Early correct diagnosis of these malpresentations was rarely made, the mistaken diagnosis of breech presentation being the most common.

X-ray examination should be resorted to if the diagnosis is not certain and repeated x-ray examinations may be very helpful as labor progresses. Because these presentations occur so infrequently repeated consultations should be the rule.

Two case reports are presented which bring out points which we feel are important in the management of these presentations.

King Kalakaua Building (H. McC. P.).
Kamehameha School (N. S.).



NILS P. LARSEN, M.D.

The President's Page

During the second week in December I was asked to present a 20 year graph showing health conditions on the sugar plantations. This 20 year period has seen more dramatic changes in medicine (due partly to the introduction of the sulpha drugs, the antibiotics and finally cortisone and associated products) than any other period in the history of medicine. We were fortunate therefore in having a system on the plantations that gave us a clinical record of the striking changes that these new advances of medicine made in lowering the morbidity and mortality rates in a large section of a rural population.

When you think that in 1923 in Hawaii, 130 people died of beriberi, 592 infants died of gastrointestinal diseases, 160 per 100,000 died of tuberculosis, and that the infant mortality rate among Filipinos was 366, it is evident that very recently Hawaii was not a Paradise of Health. Thomas Keay reported in 1936 how in his early days as plantation physician, epidemics of typhoid and diphtheria were a yearly occurrence and 62 babies died in his district alone during that year. This past year the infant mortality was down to a rate of 16, the total death rate was 5.1 whereas the U.S. reported an all time low with a rate of 9.2. There were no deaths from gastrointestinal diseases on the plantations; beriberi has disappeared; venereal disease is relatively rare, and tuberculosis is no longer a major problem. The health situation on the plantations of our island paradise is phenomenally good.

There were certain unusual procedures used to help attain this record. First, an unusually devoted, well trained team of doctors and nurses worked hard and enthusiastically. Second, hospitals with excellent facilities were available to all. Third, the planting in the laborers' yards, in 1936, of 87,000 banana trees, 19,000 papaya, 6,000 avocado, 3,000 mango, 3,000 citrus and many other trees with an average of 185 sq. ft. of vegetable gardens per capita, was positive health work. We believe this ready availability of fruits and vegetables had a great deal to do with overcoming beriberi.

Along with this went health education in schools and on the plantations. To improve rates of maternal and infant mortality, a regular system of sterilization was put in effect for all those parents for whom childbearing would be an added risk. The regular monthly infant and maternal clinics along with the delivery of practically every woman in a clean hospital setup added to the quota of improvement. The industry as well as the profession can well be proud of these accomplishments in better living.

However, we now have to recognize the rising tide of years and the increasing number of the middle-age diseases: malignancies, coronary diseases, and high blood pressure, etc. On the Kilauea Plantation, a careful survey of blood pressure recently showed that whereas there were 20 known hypertensives among the labor group prior to the survey, 69 new ones were found. Whereas there were 4 known diabetics prior to the survey, 6 new ones were found. It was also found that 40% of the adult population was over 50 and only 10% was under 30. We must keep these figures in mind for they indicate the problem we all must face in doing the best health work for our island population.

Present indications are that diet has much to do with the development of these deteriorating conditions. There are no specifics for their control but a great deal of work is being done the world around. We have an opportunity in Hawaii to make observations that probably cannot be made anywhere else.

Nils P. Larsen

Hawaii
MEDICAL JOURNAL

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[EDITORIALS]

A New Health Department Building—An Urgent Need!

It is nearly three-quarters of a century ago that the present Health Department building was built, and a quarter of a century ago that it was last enlarged.

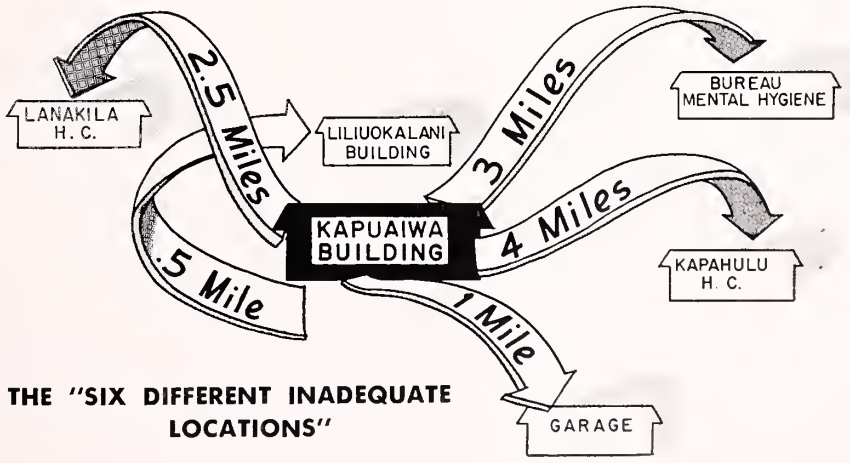
Six years have passed since the Public Health Committee of the Chamber of Commerce of Honolulu recommended that the Health Department be provided with a new building.

Five years have passed since Dr. Ira Hiscock of Yale University, in his survey of health conditions in Hawaii, referred to the reduction of services, the inconvenience to the public and employees, the handicap to morale and teamwork, and the downright hazardous conditions existing in the laboratory, all due to the deplorably makeshift and widely scattered housing facilities "enjoyed" by our Health Department.

Two years ago Dr. G. L. Dunnahoo, Acting Regional Medical Director, U. S. Public Health Service, referred to the Department of Health's "six different inadequate office locations in Honolulu." He strongly recommended the construction of a single new building to house all the Health Department's activities.

Hawaii has an excellent Department of Health, one of the best in the world. It is rendering important services to the public, and to the medical profession. Its President, Dr. Richard K. C. Lee, is a competent health officer and an able administrator. Its Director of Laboratories, Dr. Max Levine, is a distinguished, internationally known bacteriologist; an article by him on an important aspect of his work here appears elsewhere in this issue of the JOURNAL. You know of the competence of the other department heads, we are sure. These men are severely handicapped in the performance of their important duties by grossly inadequate places in which to work.

Doctor, please look into this—and if you agree, make it your business to let your legislators know, by *direct personal contact,* that this situation is an intolerable one. Tell them we *must* find the money for this new Health Department building. It is a genuine, urgent, long-existing need; it is up to you to see that the job is done!



THE "SIX DIFFERENT INADEQUATE LOCATIONS"

Inter-hospital Cooperation

Financial insecurity of one or more Honolulu hospitals was pointed to by Dr. C. M. Burgess, in his Presidential Address before the Honolulu County Medical Society last December, as one of the most important potential incentives to the development of a closed panel medical plan in Hawaii.

He warned that any hospital whose policies tend to threaten the solvency of other hospitals will thereby invite another attempt to foist closed-panel medicine upon our community. He called upon all hospitals to cooperate in the elimination of any such policies.

Dr. Burgess went on to emphasize his belief in the need for hospitals to limit the scope of their services, in the interest of efficient operation. He warned against the encroachment of general hospitals too far upon the areas served by special hospitals.

The retiring president urged physicians to consider, in choosing the hospital to which they would send their patients, first the interests of the patient, second the interests of any hospital whose solvency was in doubt, and last the interests of any hospitals whose policies might be contributing to such doubt.

We heartily endorse these views. Hospitals have a weighty responsibility to the community—one which is not discharged merely by "looking out for Number One." They must pull together, not separately. They must integrate and correlate their services to the community. Only in this way can they in the long run best serve the community—and, in so doing, themselves.

Hawaii Heart Fund Drive

February is the month of the Heart Fund drive. This important fund-raising campaign is held in all cities and states in the United States by the American Heart Association and is conducted locally by the Hawaii Heart Association, an affiliate of the national organization. The local organization, founded in 1948, is a voluntary health organization concerned with the problems of heart disease, research, and education, and a majority of the funds raised in the annual campaign is used in Hawaii for these purposes. Mrs. Sabra S. Sadler, formerly consultant nurse with the Virginia State Department of Health and author of a well-known book for parents on rheumatic fever, is the first full-time executive director of the Hawaii chapter.

During 1954 and 1955, the Hawaii Heart Association is supporting studies by Dr. Jerry K. Aikawa of the University of Colorado School of Medicine. Dr. Aikawa is investigating, with radioisotopes, the harmful exaggeration of the normal immune reaction (to the beta-hemolytic streptococcus) which probably causes the symptoms and signs we call rheumatic fever.

In addition, the Hawaii Heart Association is studying the prevalence of heart disease among children in a rural school on Oahu. The study may later be extended to other schools. The Honolulu County Medical Society and the Pediatric Society of Honolulu have approved this pilot survey.

Further educational efforts through radio, press, television and talks to Parent-Teacher Associations are planned for 1955. The Hawaii Heart Association asks the support of the medical profession in its work.

Hawaii Gets the Nod!

A national survey by the A.M.A. has included Hawaii!

The 1954 publication of the A.M.A. Council on Medical Service's survey of Voluntary Prepayment Medical Benefit Plans includes Hawaii and its Hawaii Medical Service Association; even the map contains an insert showing all the major islands of the Hawaiian group.

In the light of the A.M.A.'s long record of ignoring Hawaii in surveys of various sorts, this can probably be taken as a real compliment to the importance and significance of our H.M.S.A. It just couldn't be ignored!

Neither, *mirabile dictu,* were they able to entirely ignore medical group prepayment plans. New York's H.I.P. and California's Permanente were left out in the cold, as usual; but the Ross-Loos plan in southern California was included. The crucial point, apparently, was approval by the local county medical society, which Ross-Loos enjoys and the others do not.

It is to be hoped that the comprehensive study of medical prepayment plans authorized at the Miami meeting of the A.M.A. will include a study of the successes—and the shortcomings—of these group plans. The apparently insurmountable difficulty of integrating them with the normal type of medical practice makes them a factor to be reckoned with, and it is time the A.M.A. dropped its ostrich-like attitude toward them.

Please, Doctor! Give to the A.M.E.F.!

The American Medical Education Foundation is the *united* way for doctors to donate money to their own medical schools. Your donation to the A.M.E.F. goes intact to the school of your choice —and on the way there, it proclaims the loyalty

of doctors to the principle of free and untrammeled medical schools. Last year the income of the organization exceeded a million dollars for the first time, and allocations of funds to medical schools were raised to really substantial levels as a result.

Medical schools are having tough sledding. The chances are that your own school contributed heavily to the cost of your medical education. Costs of medical training are rising, endowment incomes are falling, and rising living costs are constantly adding to the financial burden of all schools, including the medical ones.

Federal subsidy, which neither the nation nor the schools themselves can well afford, is inevitable unless other sources of income can be found. Please make a donation to your school, or to a school of your choice, and send it to the A.M.E.F., 535 North Dearborn Street, Chicago 10, Illinois. It's an income tax deduction.

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Doctors may not take full advantage of the powerful medium of advertising in bringing their story to the public—and are usually too concerned with practicing medicine to make full use of the limited extent to which they might properly do so.

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Parke-Davis bought space in the preceding issue of our JOURNAL to tell us how they have gone about bringing medicine's message to the public, with full-page color advertisements in *Satevepost, Time, Life, Newsweek,* and other magazines of national and international circulation.

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This is What's New!

In New York, 2,000 patients with **migraine** or tension headaches have been studied over the past seven years. Prevention of both types of headaches was best accomplished with **psychotherapy.** Cafergot, either orally or rectally, was the drug of choice in the treatment of migraine attacks, while tension headaches responded best to analgesics and sedatives. (*Neurology,* 4:773 [Oct.] 1954.)

* * *

The **antispasmodics** in the form of one of the belladonna alkaloids, Banthine or Probanthine, may have an adverse therapeutic effect on ulcer patients with pyloric obstruction or gastric hemorrhage. In over half of a series of patients with pyloric obstruction treated with a belladonna preparation, there was significant **increased gastric retention.** This appeared to be due to decreased gastric peristalsis and tone. Five patients with recent gastric hemorrhages developed paralytic ileus after treatment with Banthine and Probanthine. The authors recommend that these antispasmodics be used cautiously in patients with pyloric obstruction or recent gastric hemorrhage. (*New Eng. J. Med.* [Oct. 7 and 21] 1954.)

* * *

Total **adrenalectomy** for hepatic **cirrhosis with resistant ascites** is reported from England. This procedure performed on one patient has resulted in disappearance of ascites with increased general weakness, nausea, hypotension and a fall in serum sodium. There is also increased excretion of sodium and an increased response to mercurial diuretics. (*Lancet,* 247:847 [Oct. 23] 1954.)

* * *

By the use of paper chromatography and radioactive diiodotyrosine, two Canadians have apparently demonstrated a marked effect of the **salivary glands** on thyroid hormone metabolism. These glands appear to **remove iodine from thyroxin.** Excision of the salivary glands prevents disappearance of intravenously injected diiodotyrosine. In short, the salivary glands have a function reverse to that of the thyroid. (*Science,* 120:547 [Oct. 1] 1954.)

* * *

Jaeger, of Jefferson Medical College, has treated **tic douloureux** in 14 patients by injection of 1 ml. of **boiling water** into the Gasserian ganglion. He believes this procedure to be preferable in certain patients to the use of alcohol injection or surgery. (*Science,* 120:466 [Sept. 17] 1954.)

* * *

It is estimated that in 20 to 30 per cent of patients common bile duct stones are overlooked at the time of routine abdominal exploration of the biliary tract. Operative cholangiography has reduced this error, but even with this technique the diagnosis of common duct stone was missed in 12 out of 57 patients. (*Am. Surgeon,* 20:1171 [Nov.] 1954.)

* * *

Acute hemorrhagic enterocolitis is reported as a pathologic entity. The usual picture is that of an elderly individual suffering from chronic cardiovascular disease having sudden onset of abdominal pain and diarrhea. Mesenteric thrombosis may be suspected. The patient dies in a few days with postmortem examination revealing edema, hemorrhage and ulceration of the small and large bowel. No therapy has been beneficial. (*Gastroenterology,* 27:431 [Oct.] 1954.)

FRED I. GILBERT, JR., M.D.

Perhaps It's Your Nerves

The Psychiatric Hospital Milieu

The modern psychiatric hospital exists for a much more specific function than that of mere custody of patients. It not only furnishes a center in which a skilled staff can provide specific medical therapies, but also a non-specific therapeutic effect inherent in the overall hospital program. This is essentially embodied in the removal of the patient from an environment in which he did not function adequately, and in offering him a simplified and guided daily environment. Any hospital can protect the patient against himself and protect society from the patient; but this is not sufficient. Rather, in a modern institution like the Territorial Hospital, we attempt to utilize the personnel and the available activities in a dynamic setting to alter the internal conditions of the patient's personality and resultant behavior so that it is possible for him to make a satisfactory adjustment on return to the community. This is often known as milieu therapy, or environmental therapy.

If the hospital environment is to be utilized for individually oriented therapy, each patient must be understood and each patient must be permitted to have satisfying relationships with the personnel. By satisfying we mean a relationship which may not necessarily give the patient what he feels he wants, but rather one which attempts to supply the elements which he *needs* for better psychological balance.

Thus environmental therapy is largely relationship therapy (the basic ingredient of all psychiatric treatment). The most important element in psychological therapy is that at least one person make emotional contact with the patient. The more regressed the patient, the more difficult this will be. With psychotic patients it requires a consistent, friendly, non-threatening, warm attitude. Simple permissiveness is not sufficient, nor is it always indicated. A genuine interest in the patient is essential for a therapeutic relationship.

The therapist can be any member of the hospital staff who works with patients, such as a nurse, aide, adjunctive therapist (occupational therapist, physiotherapist, recreational worker, etc.), physician, social worker, or psychologist, except that adequate supervision must be provided, and different approaches are used by each type of therapist. Therapeutic relationships are built by continued contact between patient and therapist in the development of feelings about each other. This can be done in a group situation as well as in the highly specialized situation of individual therapy.

Relationship therapy then amounts to the utilization of this relationship by the therapist with the strength and healthy potentialities toward recovery which every patient has. When necessary, he supplies control of impulses and sets reality boundaries for the patient. At other times he may find it necessary to encourage the patient in self-expression and decrease of unnecessarily rigid controls. As the relationship progresses satisfactorily, the patient identifies himself with the therapist and takes over his standards as his approach to situations which the patient is not ordinarily capable of meeting effectively. Theoretically, the patient is potentially capable of internalizing or absorbing these characteristics of the therapist. A therapist's strength becomes a part of the patient. It is apparent then that the activities and the facilities of the entire hospital must be oriented towards the same goal and also towards strengthening the therapeutic characteristics and approach of the individual therapist. The only difference is that the therapeutic planning must be done on the basis of a large group situation, and facilities must be provided to allow this to take place and to help it grow.

The necessity for supplying staff and physical facilities which will afford the patient guided experiences in various areas of living is an obvious one. He must be helped to play, to express himself, to realistically control his impulses, to face his feelings without excessive anxiety, to be useful, to learn to share friendships, to relax, and to work. In his daily hospital living and treatment program, as many of these things as possible must be attended to while specific attention is being given to personal and situational problems which contributed to his illness. There is much modern work being done in the particular area of social interaction and therapeutic work with groups. This is proving to be a highly rewarding and promising field of endeavor and it warrants much encouragement and backing.

As long as a hospital program is basically oriented toward integrating patients with a healthy group and returning them to community functioning, the treatment program will probably be effective if facilities and personnel are at least adequate.

ROBERT A. KIMMICH, M.D.



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Woman's Auxiliary

The Woman's Auxiliary will present *In Memoriam—Doctors of Hawaii* to The Hawaii Medical Association on the occasion of its Centennial in 1956. The initial undertaking was begun in 1952 as a historical scrapbook, a project of the Honolulu County Medical Society Woman's Auxiliary. It has grown to territorial proportions and now embraces the co-operative assistance of all the territorial auxiliaries. There are contained in it more than two hundred biographical sketches of deceased doctors, covering the lives of all of the doctors who have ever practiced in Hawaii. Beginning before the missionary doctors, the sketches are introduced by a description of John Elliot de Castro, physician to Kamehameha I. It continues with portraits of missionary doctors and follows through to the present time. It is a continuing project and material will be added to it as time goes on.

Mrs. Robert Katsuki is chairman of the project, and, together with her committee, has ably undertaken the task of compiling the data for the sketches. The present members of her committee are Mrs. Robert Johnston, Mrs. John Milnor, and Mrs. Vernon Boido; Mrs. Peter Washko, Mrs. Leslie Vasconcellos, and Mrs. Kikuo Kuramoto have assisted in the past. Mrs. Motokazu Mori, Mrs. Kyuro Okazaki, and Mrs. Herbert Takaki are serving as chairmen for the Japanese doctors' biographies, and are lending invaluable assistance by collecting information which they have translated from the Japanese language papers. Mrs. Fred Lam extended the same assistance for two years in respect to the Chinese doctors' biographies.

The proposal of the plan for a historical scrapbook was introduced by Mrs. J. Warren White, who is now serving as territorial chairman. The auxiliaries of the neighbor islands are contributing a great fund of information which is accessible to them through their old local newspapers. The ferreting out of this material requires much time and research, and the committee gratefully acknowledges the assistance of all those who are contributing in this work. Mrs. Nicholas Steuermann is chairman for the Hawaii Auxiliary; Mrs. Joseph M. Sowers is chairman for the Maui Auxiliary; Mrs. J. M. Kuhns is in charge on the Island of Kauai.

A very efficient method for the compiling of data has been worked out by Mrs. Katsuki in the form of a file system containing the pertinent facts of each doctor's life, as well as a bibliography. This file will be turned over to the Mabel Smyth Library upon completion of the project. Wherever there are survivors, the sketches are presented to the families to be edited in order that they may be entirely acceptable to them. The sketches consist of biographic material, as well as items of human interest. The contents of this work are not of a creative nature, but rather a compilation. Sources of information, other than survivors, are old Oahu and neighbor island newspapers; magazines: *The Friend, Paradise of the Pacific,* and *Missionary Album;* the book series, *Men of Hawaii; Pan-Pacific Who's Who; A. M. A. Journal;* and medical journals both of Hawaii and the states.

In its finished form, the work will consist of four copies. One copy will be kept in the Mabel Smyth Library; the others will be distributed to the medical societies on the Islands of Hawaii, Maui, and Kauai. The work will also be published in instalments in the JOURNAL. It will be the first compilation of its kind in Hawaii, and will, in effect, be a tribute to all those men who have practiced medicine here in the Hawaiian Islands.

* * *

Another research project in which auxiliary members participated was the spot checking of old Oahu newspapers in an attempt to locate reports of meetings of the Hawaiian Medical Society. According to the charter of 1856, the medical society had to meet once a year, yet no records of any meetings have been traced from 1856 to 1893. Mrs. Robert Katsuki, chairman of the project, has reported that the only information found was in *The Pacific Commercial Advertiser* for August 20, 1856, which contained a copy of "The Charter of Incorporation of the Hawaiian Medical Society." In the same issue was found a notice of the first meeting held on August 13, 1856, listing the officers elected for that year. Spot checked were issues from 1856 through 1893. All issues for the years 1857, 1858, 1862, and 1876 were checked in a second attempt to locate some news, but nothing was found. Especially helpful to Mrs. Katsuki in this work were Mrs. Harry Arnold, Jr., Mrs. Homer Benson, Mrs. Vernon Boido, Mrs. E. A. Fennel, Mrs. John Milnor, and Mrs. J. Warren White. Other auxiliary members also took part in the research.

MRS. L. L. BUZAID

Book Reviews

Nontuberculous Diseases of the Chest.

Edited by Andrew L. Banyai, M.D., 1139 pp., illustrated, Price $18.75, Charles C. Thomas, 1954.

The effective use of antimicrobial drugs together with advances made in anaesthesia and thoracic surgery have brought into prominence the much neglected non-tuberculous groups of chest diseases.

This volume gives an orderly presentation of these diseases together with diagnostic aids and therapeutic management by an experienced and representative group of contributors. The chapters on lung tumors are particularly well organized.

The book, sponsored by the American College of Chest Physicians, makes an excellent reference source for the practicing physician. Incidentally, Dr. P. Gebauer of Honolulu is frequently quoted.

HENRY C. GOTSHALK, M.D.

The Epilepsies.

By Henri Gastaut, translated by Mary A. B. Brazier, 149 pp., illustrated, Price $4.75, Charles C. Thomas, 1954.

This small volume is a technical presentation by one of the foremost experts in the field. It shows the intricate inter-relationship between the findings in the electroencephalogram and the varying clinical aspects of epilepsy. It should make the general medical man realize that electroencephalographic examination in epilepsy is essential to good medical practice. It gives more profound insight into the use and the interpretation of the electroencephalogram to those who are familiar with the basic fundamentals.

The book is well written and well illustrated, and its discussions of the clinical aspects of epilepsy are in themselves worthwhile studying. Epilepsy is an important medical problem. This book will add materially to the knowledge of the clinical aspects of epilepsy and its correlation with the electroencephalographic findings.

J. ROBERT JACOBSON, M.D.

Treponematoses.

By T. Guthe, M.D., M.P.H. and R. R. Willcox, M.D., 79 pp., illustrated, Price $.50, Columbia University Press, 1954.

This book brings together in brief and readable form much of the information and many of the ideas expressed during the past several years by the World Health Organization concerning the treponematosis problem. It calls everyone's attention to the immensity of the treponematosis problem both in geographic distribution and economic waste. It brings to the physician new concepts of treponematosis control and restates to the health worker the philosophy of using a single disease control program as a means of developing generalized public health programs. Present control programs throughout the world are described.

SAMUEL D. ALLISON, M.D.

Diseases of the Skin.

By George Clinton Andrews, M.D., F.A.C.P., 877 pp., illustrated, Price $13.00, W. B. Saunders Company, 1954.

The author, a distinguished American dermatologist, has presented his completely revised (4th) edition. Many chapters have been modernized to keep abreast with new concepts in diagnosis and therapeusis. It is an excellent dermatologic atlas of 777 illustrations of common and rare skin lesions. There are splendid discussions on such topics as junctional nevus and melanoma, metabolic diseases pigmented manifestation of internal disease, and the collagen diseases including the L. E. phenomenon.

This book is unusually free of redundant and portentous terminology so typical of some dermatologic texts. Dr. Andrews deserves the "Medical Oscar" for presenting this valuable edition.

HAROLD M. JOHNSON, M.D.

The Clinical Use of Corticotropin, Cortisone and Hydrocortisone in Eye Disease.

By Dan M. Gordon, M.D., 88 pp., illustrated, Price $5.50, Charles C. Thomas, 1954.

This monograph rather completely discusses the value of the above preparations in all phases of eye disease, but their tabulated statistics are their own which were worked out at the Cornell Medical Center. It is the reviewer's belief that in the final evaluation of the various preparations a compilation of statistics would have been of more value.

The use of topical cortisone in the eye for uveitis has no logic and in my experience very little value. The author fails to distinguish between topical use and subconjunctival use in his statistics of cases treated with "local" cortisone (Table, Page 78).

The monograph has nothing particular to offer other than that which can be obtained from the literature, but it does furnish a ready source of information and is a neat, well tabulated review.

O. D. PINKERTON, M.D.

Peripheral Circulation in Man.

Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., and Jessie S. Freeman, M.B., B S., D.P H., 219 pp., Price $6.00, Little, Brown and Company, 1954.

This book is written largely for the experimental physiologist. There is little of interest for the practicing clinician. It covers the methods for studying blood flow, the change in circulation due to exposure to cold or heat, the neurohistology and reflex control of the circulation and the effects of sympathectomy, and the significance of cold agglutinins. The best chapter is the one on the pathology of peripheral arteries. The book is not too well written; I doubt that many will read it.

JOHN L. BELL, M.D.

Handbook of Emergency Toxicology.

By Sidney Kaye, B.S., M.Sc., 303 pp., Price $5.75, Charles C. Thomas, 1954.

This book lives up to its name. It is a concise compilation of the commonest toxic substances likely to be encountered in an emergency room or a doctor's office, with a good description of the appropriate treatment and how to recognize the poison.

It includes a discussion of the use ot versenes in the treatment of lead poisoning, which is a rather recent development.

As usual, there are some features less desirable. For example, the discussion of weed poisons is confined entirely to arsenical poisons, whereas—in this community at least—dichlorphenoxy-acetic acid or Weedone is much more widely used. It is also toxic, but not nearly as seriously so as arsenic. In the compilation of poisons, the author mentions a weed killer called Weedon, which he says contains arsenic. It may be that there is a Weedone as well as a Weedon on the market. He makes the statement that putty contains lead. This is some very strange type of putty, because putty is normally a mixture of whiting and linseed oil, and does not contain lead unless pigments containing lead have been added to it. The book also fails entirely to mention the most common insecticides used, in this community at least, such as Chlordane, Pentachlorphenol, Lindane, Malathon, and so forth. Since there is no very effective treatment for poisoning with these substances anyway, this omission is probably not very serious.

On the whole, the book is to be recommended because it is concise and it has the best list of toxic substances I have seen in any book.

H. L. Arnold, Sr., M.D.

Surgery of the Adrenal Glands.

By William Wallace Scott, M.D., Ph.D. and Perry B. Hudson, M.D., 150 pp., illustrated, Price $3.50, Charles C. Thomas, 1954.

The adrenal glands within the past few years have been the subject of extensive investigation. Current literature regarding their multitudinous activities has reached voluminous proportions. Many of the conclusions drawn are contradictory but much has been learned that the clinician can apply daily for the benefit of his patients.

This monograph deals with both the normal and abnormal activities of these structures. It is difficult to present this subject in a manner for easy comprehension, but these authors have done a commendable job, considering the space at their disposal and the confused state of knowledge of the subject. The embryologic development, structure and function of the adrenals and their relationship to the diagnosis and treatment of adrenal tumors occurring both in the cortex and medulla are discussed. A brief chapter is devoted to the subject of bilateral adrenalectomy in the treatment of disseminated cancer of the prostate and breast.

This monograph is a valuable reference for those interested in attempting to keep abreast of the rapidly unfolding knowledge of these important organs, the knowledge of which has been so nebulous in the past. It is particularly valuable as a ready reference when one is confronted with an individual in whom an adrenal tumor is suspected.

J. E. Strode, M.D.

Legal Medicine.

By R. B. H. Gradwohl, M.D., 1093 pp., illustrated, Price $20.00, C. V. Mosby Company, 1954.

This first edition of a long needed volume on legal medicine, edited by one of the foremost men in the field, presents in a little over 1000 pages a wealth of *modern* information in the field of legal medicine. It is clearly and concisely presented and each particular problem is presented by a specialist in his own field. It is a source book par excellence for the medical examiner and presents interesting and intriguing material for the entire profession. The book fills a need of long standing for a textbook of legal medicine.

Alvin V. Majoska, M.D.

The Care of the Aged.

By Malford W. Thewlis, M.D., Sixth Edition, 832 pp., illustrated, Price $15.00, C. V. Mosby Company, 1954.

The author, Malford W. Thewlis, has drawn upon his long experience to complete this book, "The Care of the Aged." Dr. Thewlis has been one of the pioneers in the United States in attempting to improve the care of the elderly patient. He is the guiding light of the American Geriatrics Society and could very well be considered the first specialist in geriatrics and gereology in in the United States.

His descriptions of treatment and diagnosis of the elderly patient generally conform to those found in many textbooks for the care and treatment of the average individual. However, due to his long experience, he has added many points which he has found to be highly successful in the treatment of these people, particularly as to variations in diagnostic symptoms and science, as well as variations in response to drug and surgical therapy.

A word of caution must be added here, that many of the points which Dr. Thewlis has derived from his experience may not "hold water" from a scientific standpoint. Therefore, these must be analyzed carefully if one is to adapt them to his armamentarium.

Statistics of the growth in our population and comparative ages of our population as well as statistical material pertaining to geriatrics and gereological science are liberally used in bringing out many of the points which Dr. Thewlis emphasizes.

All in all, such a book as this should prove a valuable addition to our library of medicine.

F. L. Giles, M.D.

Principles of Neurological Surgery.

By Loyal Davis, M.S., M.D., Ph.D., D.Sc. (Hon.), 544 pp., illustrated, Price $8.50, Lee & Febiger, 1953.

This fourth edition brings up to date one of the standard textbooks in neurosurgery. No attempt is made by the author to completely cover the field and matters of surgical technique are discussed very little.

Because of its handy size, one can often in a few pages in this book get a good picture of what can be accomplished by neurosurgery in various conditions. For this reason, the book should be popular with medical students and non-specialists. The large clear type, detailed table of contents and adequate index make for easy reading and the rapid location of appropriate subject matter.

John J. Lowrey, M.D.

Clinical Approach to Jaundice.

By Leon Schiff, M.D., Ph.D., 113 pp., illustrated, Price $3.75, Charles C. Thomas, 1954.

This brief monograph contains a wealth of information on the diagnostic approach to the jaundiced patient. The author effectively integrates the history, physical examination, laboratory, x-ray, and, when necessary, needle liver biopsy, into a satisfactory diagnostic approach. The busy general practitioner seeking information will find his answer concisely and clearly in this little volume. The house staffs should put this on their "must read" list.

RAYMOND M. DEHAY, M.D.

Nerve Blocks.

By John Adriani, M.D., 265 pp., illustrated, Price $6.50, Charles C. Thomas, 1954.

This has been a long awaited manual on regional anesthesia. Dr. Adriani has superb ability to reduce technical procedures to outline form, supplemented by ample illustrations. All practitioners of medicine and surgery can find "Nerve Blocks" a useful reference because in a few minutes one can determine the diagnostic, therapeutic or anesthetic indications and limitations of any regional anesthetic procedure described. Thereafter, it is a simple matter to review by outline and diagram the techniques of nerve blocking and through adherence to suggested precautions minimize anticipated complications. I might add that volumes of solutions suggested are minimal, and for the occasional nerve block these volumes could be increased substantially to assure success where needle placement is not well practiced.

CARL E. JOHNSEN JR., M.D.

The Mechanism of Labour.

By Erik Rydberg, M.D., 180 pp., illustrated, Price $4.75, Charles C. Thomas, 1954.

The student of the mechanism of labor will find this book by Dr. Rydberg to be a masterpiece in the analysis of the processes which the fetus goes through in order to get through the birth canal at or near term. At first, I was rather bored by the theories which are discussed at great length. If the reader can stifle his boredom and persist on into the latter half of the book, he will be well rewarded.

I believe it is a book that will be most useful to teachers of obstetrics, theoretical and practical, and to those who are sincerely enough interested in the study of prolonged labor to want to know why various attitudes of distortion occur, and why it is that they progress in peculiar and atypical manners as the fetus works its way on down through the tortuous birth canal. The models, particularly of distorted fetal heads, which have been constructed by Dr. Rydberg, and his ingenious way of measuring the fetal head of the live or dead baby in making these models, are most intriguing. Even though it may not reduce the incidence of prolonged labor or have much effect on fetal and neonatal mortality, the true student of prolonged labor would do well to give this book some careful attention.

I must say that my boredom has completely subsided, and if I possessed a hat, I would take it off to this author.

H. E. BOWLES, M.D.

Fundamentals of Internal Medicine.

By Wallace Mason Yater, M.D., Fourth Edition, 1276 pp., illustrated, Price $13.50, Appleton-Century-Crofts, Inc., 1954.

The latest edition of Dr. Yater's now well-known text has again brought to the student and busy practitioner the comprehensive review of internal medicine that has long been noted for its brevity with little loss of content. There are numerous lists and tables wherever the similarity of diseases make this desirable. The topics selected for discussion, as well as those rarer conditions that are merely mentioned, are amply supplied with recent bibliographies for further study. The chapters on the important subjects of medical ethics and the social and financial aspects of practice will provide interesting reading for all physicians. The sound and sensible presentation of all topics reflects the author's many years of teaching internal medicine to students and insures the continued popularity of his "Fundamentals."

ROBERT V. CHOISSER, LT., MC, USNR

The Auxiliary Heart.

By William Walter Wasson, M.D., 184 pp., illustrated, Price $10.50, Charles C. Thomas, 1954.

This interesting and stimulating monograph is the result of the author's interest for the past 30 years in the importance of the pulmonary circulation as an auxiliary heart. He has described briefly the psychodynamic forces which, working in coordination and considered as a unit force, comprise the auxiliary heart. He has stressed the importance of the surgeon, the clinician and the radiologist being able to visualize the microscopic anatomy of the lungs, the air cells and the elastic fibers, the intrapulmonary air pressures, the capillaries and the capillary blood flow, the lymphatics and the lymphatic flow. He feels that early recognition, diagnosis and treatment of the diseases which interfere with the function of the auxiliary heart will prevent many cardiac failures in the operating room and the sick room.

Although the subject matter is brief, the various aspects of the pulmonary circulation are well considered. A very important feature of the book is the extensive bibliography which should stimulate further reading for those interested in the subject and also will serve as a valuable source for those working or writing in this field. A very interesting and well-written historical chapter by Mindell W. Stein is included.

RICHARD D. MOORE, M.D.

Human Biochemistry.

By Israel S. Kleiner, Ph.D., Fourth Edition, 746 pp., illustrated, Price $7.50, C. V. Mosby Company, 1954.

This book shows a clear and well organized consideration of the subject of physiological chemistry. However, it belongs in the general category of a text rather than a medical reference, and it could not be recommended to the physician for any other purpose. It contains an excellent index, as well as valuable references, which would render it particularly useful to a student of biological chemistry.

LT. EMIL G. SHAW, MSC

Legg-Calve-Perthes Syndrome.

By Charles Weer Goff, M.D., 332 pp., illustrated, Price $10.75, Charles C. Thomas, 1954.

Charles Goff in his book of osteochondroses of youth has presented a comprehensive review of the literature on osteochondroses with particular reference to Legg-Calve-Perthes Syndrome, and in addition has summarized the management and theories of treatment used at the Newington Home for Crippled Children in Newington, Connecticut. Some interesting aspects of growth and growth stimulators are incorporated in the book, but no dramatic changes in management or treatment methods are brought forth. While the book is an excellent one for reference, and covers the subject of Legg-Calve-Perthes Syndrome in detail, the reading is somewhat difficult because of the statistical and analytical nature of the writing. It is a valuable contribution to the reference literature and should be available to any orthopedist interested in the osteochondroses.

IVAR J. LARSEN, M.D.

Fundamentals of Neuropathology.

By William Brooks Dublin, M.D., 685 pp., illustrated, Price $18.50, Charles C. Thomas, 1954.

This book is one of the latest of a harvest of volumes covering a subject on which there was a dearth of texts up to a few years ago. To this reviewer it is also the best of the works of recent years, despite the fact that the useful and simplified Kernohan classification under which he was trained is not emphasized in the section on tumors. This book's greatest asset, and its margin of superiority over other publications on the subject, is its numerous excellent black and white and color illustrations. If one picture is worth 1,000 words, then this volume is really double its 685 pages. Furthermore, the illustrations are of high technical quality.

Physically the cover is solid, the binding is good for a large book, and the print is large, legible, and well spaced.

This is a helpful volume for those who occasionally are faced with neurological problems, but it is a must for neurologists, neurosurgeons, and general as well as neuropathologists.

W. HAROLD CIVIN, M.D.

Review of Medical Microbiology.

By Ernest Jawetz, Ph.D., M.D., Joseph L. Melnick, Ph.D., and Edward A. Adelberg, Ph.D., 360 pp., Price $4.50, Lange Medical Publications, 1954.

As far as I know, this is the first book of this type. It brings into clinical focus the important aspects of biochemistry, bacteriology, chemotherapy, and mycology, as well as an intensive study of the viral diseases.

Aside from the many basic reviews necessarily included in a text of this sort, I would say the outstanding reason this is an excellent book is that for the first time there is a blending of the pertinent sciences which have contributed so much to the progress of medicine in the past decade. For the doctor who has just finished his training in a medical center, this book will be an excellent source of reference. For those who have been away from school and training centers for more than a couple of years, this book should be not only a refresher of some of the basic concepts in bacteriology and biochemistry, but it should serve to point up the advances in treatment and a much better understanding of the whys and wherefores of viral, bacterial, and rickettsial diseases.

I would strongly recommend *A Review of Medical Microbiology* for every physician's library. To my own way of thinking, it marks the most important advance in medical textbooks during the past several years.

MORTON E. BERK, M.D.

Nash's Surgical Physiology.

Edited by Brian Blades, M.D., Second Edition, 686 pp., illustrated, Price $12.50, Charles C. Thomas, 1953.

This well printed volume gives the essentials of physiology that should guide the practicing surgeon in the understanding of his operative procedures as well as the proper evaluation of patients both pre- and post-operatively.

The inspiration for the original volume was Dr. Arthur Wright—a task-master who always emphasized the importance of the basic sciences in the practice of surgery. This second edition is contributed largely by the surgical department of George Washington School of Medicine.

Much detail is omitted, which makes this volume more readable for the general surgeon. Moreover, there is sufficient material included for example, in such rapidly changing subjects as cardiovascular surgery, fluid and electrolyte balance, anesthesia, etc., as to make this book very practical. The printing is good and there is a full bibliography. This is an excellent reference for all practicing surgeons.

SAMUEL L. YEE, M.D.

Etiology and Diagnosis in the Treatment of Infertility in Men.

By Robert S. Hotchkiss, M.D., 73 pp., Price $2.50, Charles C. Thomas, 1952.

Etiology and diagnosis in the treatment of infertility in man is admirably treated by Robert Hotchkiss in less than 50 pages. There is a short but comprehensive review of the male reproductive organs. The clinical and laboratory aspects of male infertility are well covered. The monograph ends with a discussion on testicular biopsies. There are numerous illustrations, graphs and adequate number of photomicrographs to illustrate the text. The monograph is particularly recommended as a clinical guide to those interested in this field.

SHOYEI YAMAUCHI, M.D.

Legal Medicine, Pathology and Toxicology.

By Thomas A. Gonzales, M.D., Norman Vance, M.D., Milton Helpern, M.D., and Charles J. Umberger, Ph.D., Second Edition, 1349 pp., illustrated, Price $22.00, Appleton-Century-Crofts, Inc., 1954.

This book is an extension and modification of the first edition and is really the authoritative tome on this subject. It is comprehensive and well written and certainly the illustrations are realistic. The index is well arranged and the references are abundant. Most of the problems of legal medicine are covered very thoroughly by the experts composing this work. The authors can lay real claim to the appellation "expert" since they are the guiding lights of, and have behind them experience in medicolegal work of, the largest city in the world.

(Continued on Page 258)

The Honolulu County Medical Library

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Recent Acquisitions

Biochemistry

Jawetz, Ernest. *Review of medical microbiology.* c1954. (gift of publisher).
Kleiner, I. S. *Human biochemistry.* 4th ed. c1954. (gift of publisher).

Cancer

Ackerman, L. V. *Cancer: diagnosis, treatment and prognosis.* c1954. (gift of publisher).
Hoffman, J. G. *The size and growth of tissue cells.* c1953. (gift of publisher).
Meigs, J. V., ed. *Surgical treatment of cancer of the cervix.* c1954. (gift of publisher).

Cardiology

Wasson, W. W. *The auxiliary heart.* c1954. (gift of publisher).
Wolstenholme, G. E. W., ed. *Peripheral circulation in man.* 1954. (gift of publisher).
Wright, I. S. *Myocardial infarction.* c1954. (gift of publisher).

Chest Diseases

Banyai, A. L., ed. *Non-tuberculous diseases of the chest.* c1954. (gift of publisher).
Drinker, C. K. *The clinical physiology of the lungs.* c1954. (gift of publisher).

Dermatology

Andrews, G. C. *Diseases of the skin.* 4th ed. c1954. (gift of publisher).
Canizares, Orlando. *Modern diagnosis and treatment of the minor venereal diseases.* c1954. (gift of publisher).
Sulzberger, M. B. *The clinical significance of disturbances in the delivery of sweat.* c1954. (gift of publisher).

History

Staley, M. E. *A tapestry of memories.* c1954. (gift of Dr. Florine).
U. S. Navy Medical Dept. *The History of the Medical Department of the United States Navy in World War II.* v.1. 1953. (gift of U. S. Navy Medical Department).

Neurology and Psychiatry

Adriani, John. *Nerve blocks.* c1954. (gift of publisher).
Bullis, H. E. *Human relations in action.* c1954. (gift of publisher).
Gastaut, Henri. *The epilepsies.* c1954. (gift of publisher).
Hoch, P. H. *Depression.* c1954. (gift of publisher).
Kutash, S. B. *The graphomotor projection technique.* c1954. (gift of publisher).
Lassek, A. M. *The pyramidal tract.* c1954. (gift of publisher).
Redl, Fritz. *Children who hate.* c1951. (gift of Dr. Florine).

Nursing

Adkins, D. C. *Construction and analysis of achievement tests.* 1947. (from Nurses' Association).
Brown, E. L. *Nursing for the future.* c1948. (from Nurses' Association).
Koos, E. L. *The sociology of the patient.* 2nd ed. c1954. (from Nurses' Association).

Obstetrics & Gynecology

Hotchkiss, R. S. *Etiology and diagnosis in the treatment of infertility in men.* c1952. (gift of publisher).
International Congress on Gynecology and Obstetrics. *Prophylaxis in gynecology and obstetrics,* Geneva, July 26-31, 1954. (gift of Dr. Robert White).
Reynolds, S. R. M. *Clinical management of uterine forces in pregnancy and labor.* c1954. (gift of publisher).
Rydberg, Erik. *The mechanism of labour.* c1954. (gift of publisher).

Ophthalmology

Gordon, D. M. *The clinical use of corticotropin, cortisone and hydrocortisone in eye disease.* c1954. (gift of publisher).

Orthopedics

Adams, R. D. *Diseases of muscle.* c1954.
Goff, C. W. *Legg-Calvé-Perthes syndrome.* c1954. (gift of publisher).

Pediatrics

Bender, Lauretta. *A dynamic psychopathology of childhood.* c1954. (gift of publisher).
Jeans, P. C. *Essentials of pediatrics.* 5th ed. c1954. (from Nurses' Association).
McCullough, Wava. *Illustrated handbook of child care.* c1954. (from Nurses' Association).
May, C. D. *Cystic fibrosis of the pancreas in infants and children.* c1954. (gift of publisher).

Surgery

Brown, J. B. *Neck dissections.* c1954. (gift of publisher).
Davis, Loyal. *Principles of neurological surgery.* 4th ed. rev. c1953. (gift of publisher).
Gross, R. E. *Surgery of infancy and childhood.* c1953.
Nash, Joseph. *Surgical physiology.* 2nd ed. rev. c1953. (gift of publisher).
Scott, W. W. *Surgery of the adrenal glands.* c1954. (gift of publisher).

Tropical Medicine

Harvard School of Public Health. *Industry and tropical health.* Proceedings . . . 1st Industrial Tropical Health Conference, Dec. 8-10, 1950.

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Bureau of Medical Economics

Some people say that most doctors here are not really interested in the welfare of their patients. They are just interested in shoving their patients through their offices as fast as possible. Have you heard people say this? (if yes) Do you believe it is true or not? What do you think of this?

The above are but a few of the many questions asked by Territorial Surveys for the Honolulu County Medical Society in 1950. I think a review of the opinions expressed may help your Patient-Doctor relationship.

The survey stated that "Doctors of Oahu enjoy a most enviable public opinion climate. This fact should not be allowed to breed complacency. There is room for improvement."

The Bureau goes on the assumption, as did the survey, that doctors in the Honolulu County Medical Society are more interested in repairing the weak spots in their public relation fences than in getting pats on the back for their strong points.

In response to the above questions, 33% answered that they heard people say "*most* doctors here are not really interested in the welfare of their patients. They are just interested in shoving their patients through their offices as fast as possible," and only 56% of these people do not believe what they have heard.

This means that one patient out of three entering your office has heard these statements made, and the chances are almost even that he either believes it or is undecided as to its accuracy.

In looking over the actual answers obtained in the survey, it appears that most dissatisfaction stems from a lack of explanation to the patient. Explanation of what? An explanation of what the patient wants. *Explain* what the pills, injections, medicine etc., are for; *explain* to the patients what their trouble is, using an understandable vocabulary. Don't rush patients when they are sincerely trying to ask a question. Perhaps some questions seem silly and inconsequential, but they are of vital importance to the person concerned. Don't brush off a discussion of fees. Be certain that when a patient leaves your office, all his questions have been answered.

My wife and I visited a doctor's office recently, and we were most impressed with what we considered an outstanding public relations feature.

On one wall were nine anatomical charts. It is my understanding that these charts cover all the systems of the body. The doctor explained to us that he used these charts with his patients so that they could more clearly understand their difficulties, along with a simple explanation of the illness.

I can think of numerous times when we would have been put more at ease with an explanation along with one of these charts. I am sure that this doctor's patients feel that he is really interested in their welfare. This same doctor has the A.M.A. plaque "To All My Patients" prominently displayed in his office. (These plaques are available at the Medical Society office for $1.00.)

The following suggestion for improving personal PR is quoted from the *PR Doctor,* March 1954:

> Dear Friends: The thought occurred to me that opening a great stack of bills around the first of every month can be pretty unpleasant. For some reason or other, doctor bills come in for more than their share of abuse, especially by joke writers. I've noticed that one of the downtown stores that sends bills to my wife every month encloses a bit of blotting paper with a sample of perfume in each bill. This, then, is my attempt to make one of the most unpleasant parts of medical practice a little less distasteful. . . .

With these words Dr. Bernard P. Harpole of Portland, Oregon, launched his *series of monthly letters to his patients* in July, 1952. Dr. Harpole's mimeographed letters now go to over 400 patients and bring to them in informal, conversational style information on such subjects as immunization, child care, cancer, heart disease and other health topics. He avoids scare subjects such as polio epidemics unless he can give his patients some reassurance. He also is frank about a doctor's limitations and when sensational stories about medicine appear in the press, he gives his patients the proper perspective about them. Occasionally, he gives his readers "a look behind the reception room," so they'll understand the mechanics of his work and the problems he faces.

Dr. Harpole's letters are so popular that during the past year he had more than 90 requests to be placed on the regular mailing list. He has developed the following set of standards for his letters:

1. If the subject is "scarey," *always reassure.*
2. Speak as much as possible in terms of *us* as a *profession,* rather than me as an individual.
3. *Don't even infer* any *special talent* treatment or ability not shared by other doctors.
4. Make no effort to "drum up business" by advising people to come in for some special "shot" or treatment.
5. *Keep the subject matter simple* and use a small word instead of a big one. Avoid "terms of the trade."

His warm friendly and informative letters bring Dr. Harpole closer to his patients and do much to restore the personal element in the doctor-patient relationship. He writes that he has "enjoyed this letter project a lot and so do [his] patients." He concludes that *a continuing series of letters is much more effective than an occasional blast* when the medical profession needs public support.

The Bureau feels that a patient who knows that he can discuss matters with his doctor without being brushed off will never turn up in a collector's files. *Why not review your PR fences today?*

R. M. KENNEDY
Executive Secretary

Blue Shield Plan
for Hawaii®

HMSA—Its Place in the Community

Report on the Western Regional Conference of Blue Shield Plans

J. R. VELTMANN, *General Manager*

Last October, a conference of all Western Regional Blue Shield Plans was held in Victoria, British Columbia. As a member plan of the Western Regional Conference, HMSA was represented by the writer. Blue Shield Conferences are far from being social conventions. They consist of a series of "workshop" periods, wherein discussion groups review various aspects of medical insurance. This Conference was attended by approximately 125 doctors and plan managers.

Many important and interesting papers dealt with Medical Care for the Aged and Indigent; Liaison between Medical Profession and the Medical Plan; Hospital Services in British Columbia; and Teaching of Medical Economics in Medical Schools.

I was invited to give a paper on our local operations during the discussion period on "Changing Times for Prepaid Medical Contracts." Representatives at the Conference were interested in our efforts to develop a community medical plan to insure free choice of physician and maintain medical practice as a free enterprise. Conference members hope Hawaii will succeed in keeping out "closed panel" medical plans.

An address by E. M. Weston, President of the Washington State Federation of Labor, outlined Labor's viewpoint on medical plans. He emphasized the need for state-wide coverage, and for including the unemployed, aged and retired; for control over climbing costs of medical care; for more preventive medicine, and for more adequate public relations by medical plans with Union groups and the community as a whole.

HMSA and the medical profession hope that Hawaii will have its answer to several of these points by adoption of a proposed Community Medical Plan under study by a special committee of the medical profession. The matter of control of climbing costs of medical care can best be answered by cooperative efforts to keep hospital costs from spiralling. It is believed that joint action by the local hospital council and the medical profession could result in stabilized hospital costs to the advantage of the public.

Mr. Weston pointed out that three years ago the great bulk of prepaid medical coverage, was on a voluntary group, self-pay basis. The situation has been drastically changed by the amazing increase in labor and employer Trust Fund Plans. These have forced the nonprofit plans into two businesses—selling prepaid medical care on a group basis, and competitive underwriting with indemnity companies of prepaid insurance providing for "retentions and dividends" in negotiated contracts.

HMSA finds itself subject to criticism by the labor trustees of the Trust Funds because as a voluntary nonprofit plan, the Association does not operate on the basis of "cash retention or dividends." The Association does rate certain groups, and if their experience is good, we provide dividends in the form of "increased benefits or a reduction in subsequent monthly dues," but not in the form of cash payments. For the past three years all members of the Association have received "dividends" in the form of increased benefits without increasing monthly dues.

It was most encouraging to find that HMSA was one of the most progressive plans in the region. Benefits offered by HMSA were far more liberal and rates were reasonable. We know that all of this has been possible only as the result of the excellent spirit of cooperation as evidenced by the medical profession effort to provide the people of Hawaii with a good medical plan.

Hawaii Medical Association

A.M.A. Delegate's Report

Veterans' medical care, the government's health re-insurance plan, geriatrics, internships, grievance committees, osteopathy, the doctor-draft law, and malpractice insurance were among the major subjects taken up by the House of Delegates at the AMA's Eighth Clinical Meeting held Nov. 29-Dec. 2 in Miami. Total registration of Miami's first AMA convention ran about 7,500 of which approximately half were physicians, the remainder comprising some 900 exhibitors, residents, interns, nurses, and guests.

At the opening session AMA president, Dr. Walter B. Martin told the House that "medicine belongs to the people,"—"physicians are merely the purveyors" of medical care,—with obligations "that go beyond our own private practice into the community"; and emphasizing the importance of continued efforts to meet the medical needs of low income and other non-insurable groups.

Acting on a personally-delivered invitation by American Legion's National Commander Mr. Seaborn Collins, wherein he suggested joint Legion-AMA study of veteran's medical care, AMA's Trustees appointed 3 doctor-members as its representatives. The Commander's clear, temperate presentation of government policy on veteran's medical care, and the American Legion's position on such matters, was well received by the House, and should go a long way toward ending AMA-Legion feuding.

Concerning medical care benefits for dependents of military personnel, the Miami meeting adopted no definitive position, suggesting however that "if it is to be the policy of the government to provide for medical care for dependents of service personnel, the services of civilian physicians and hospitals be used wherever possible, to be paid for at prevailing rates, with provision for free choice of physicians."

While there was no official reaffirmation of opposition to the Eisenhower-backed reinsurance of voluntary health coverage, the delegates listened attentively to the exposition of the pros and cons by HEW Secretary Oveta Culp Hobby and Edwin J. Faulkner, insurance executive. Mrs. Hobby, presenting the case for the Administration's proposal said, "The health re-insurance proposal represents what we believe to be a necessity. It offers opportunity for self-help without subsidy." Your delegate, along with many others, judging by the applause, was more impressed by Faulkner's reasons why the proposed program "would be foredoomed to disappoint its proponents." A member of the Insurance Committee of the US Chamber of Commerce and past-president of the Health and Accident Underwriter's Conference, Faulkner said voluntary health insurance has had amazing growth without Federal stimulus.

During the meeting the Board of Trustees announced the appointment of a 13 member Commission to make a comprehensive study of all types of prepaid medical services available in the U.S. This commission, headed by Dr. Leonard W. Larson, member of the Board, will begin work immediately and will require at least a year to complete its survey.

The possible creation of a section of Geriatrics within the structure of the AMA was embodied in a resolution which was passed by the House for study by the Board of Trustees. Such a section would co-ordinate the work of already-existing or new state and local groups on geriatrics,—educate the public to the needs of the increasing older-age groups, and "advance medical care rendered to older persons."

A painstaking, constructive report focusing attention on flaws in internship practices and recommending corrective action, was accepted by the House with an expression of gratitude to the special committee headed by Dr. George Klumpp, and directed that its findings be used as a guide to the Council on Medical Education and Hospitals. This report covered the general scope of intern training facilities, noting the shortage of interns available to fill vacancies; praised the quality of intern program in Federal hospitals; made suggestions on training of graduates of foreign medical schools; and recommended "with the resurgent emphasis on the family doctor with adequate hospital training, the requirements of the profession may result in a larger number of programs and the establishment of standards in the field of general practice designed to meet this need." Noting that there are about 3,000 more internships than there are interns available, and that this discrepancy will exist despite growth of new medical schools,—the committee suggested a requirement based on filling a percentage of approved internships and a time limit to eliminate some of the unhealthy aspects of the situation. The following requirement was recommended: "Any internship program which in two successive years does not obtain one-fourth of its stated intern complement be disapproved for internship training."

The House endorsed termination of the Doctor-Draft Law which expires June 30, 1955, but granted the Board of Trustees and the Council on National Defense power to handle any new situation which might develop.

Two resolutions and a Trustees' supplemental report, all dealing with the problems and difficulties in obtaining satisfactory professional liability insurance, were considered. The House accepted the reference committee's report which indicated the Board of Trustees had a study under progress on the subject which it planned to complete for the next session.

A revival of AMA's National Education Campaign a la Whitaker-Baxter, to combat what it views as a rising menace of socialistic legislation, was embodied in a resolution from the Oregon delegation. Such a step was unanimously rejected on the floor upon recommendation of the reference committee. Alternatively, however, in response to a somewhat similar Michigan resolution, the Speaker of the House of Delegates was directed to name a committee to explore the feasibility of expanding the administrative and fact-finding facilities of the AMA headquarters.

HOMER M. IZUMI, M.D.
Delegate

County Society Reports

Honolulu

The Honolulu County Medical Society's social at the Oahu Country Club on November 2 was an outstanding success. Approximately 110 doctors and wives attended.

Cocktails and Hawaiian music were by courtesy of Pfizer Laboratories. A highlight was "The Life and Loves of a Mandarin," a pantomime, written and narrated by Mrs. Joseph Lam and produced by Mrs. H. Q. Pang. Participants in the production were Dr. Robert B. Faus playing the title role, with Mesdames Alice Chang, Duke Cho Choy, Theodore T. Tomita, Chew Mung Lum and Randal Nishijima playing wives numbers one through five.

The dinner was excellent and a good time was had by all.

J. M. Felix, M.D.
Secretary

The annual meeting of the Honolulu County Medical Society was held on Tuesday, December 7, 1954 at 7:30 P.M. in the Mabel Smyth Auditorium. Dr. C. M. Burgess presided and approximately 140 members attended.

Dr. Homer M. Izumi briefly outlined the highlights of the AMA's interim session held in Miami, November 29 through December 2, 1954. [A detailed report appears elsewhere in this issue—Ed.]

Dr. Frederick L. Giles, Chairman of the Territorial Professional Services Committee, reported that their committee, designed to coordinate medical, surgical and hospital care throughout the community working toward allowing the maximum service to the patient for the least possible cost, hopes that the new plan, when submitted to the Society, will be acceptable.

The following committee reports, on motions duly made and carried, were approved and place on file:

Secretary's Report—Dr. J. M. Felix
Treasurer's Report—Dr. Toru Nishigaya
Board of Censors—Dr. Samuel L. Yee
Diabetes Detection Committee—Dr. Morton E. Berk
Emergency Medical Service Committee—Dr. Robert B. Faus
Fee Adjustment Committee—Dr. B. Allen Richardson
Legislative Committee—Dr. Samuel D. Allison
Medical Committee of HMSA—Dr. Rodney T. West
Medical Practice Committee—Dr. R. C. Durant
Postgraduate Committee—Dr. Morton E. Berk
Program Committee—Dr. A. S. Hartwell
Public Service Committee—Dr. Sylvia Haven
Bureau of Medical Economics—Mr. R. M. Kennedy
Woman's Auxiliary to the Honolulu County Medical Society—Mrs. Betty Liljestrand
President's Address—Dr. C. M. Burgess

The report of the Nominating Committee was read and adequate opportunity was given for nominations from the floor. Election was by written ballot and the following were elected:

Dr. R. C. Durant, *President*
Dr. J. M. Felix, *Vice President*
Dr. Toru Nishigaya, *Secretary*
Dr. R. T. West, *Treasurer*

Board of Governors (for two years)
Dr. Duke Cho Choy
Dr. John P. Frazer
Dr. Paul Gebauer
Dr. Clifford K. Kobayashi

Alternate Board of Governors (for one year)
Dr. L. C. Beck
Dr. R. G. Johnston
Dr. Edmund L. Lee

Representatives to HMSA (for two years)
Dr. John L. Bell
Dr. R. T. West

Fee Adjustment Committee (for three years)
Dr. John J. Lowrey
Dr. Ivar J. Larsen

Medical Practice Committee (for two years)
Dr. Harold M. Johnson
Dr. Edward F. Cushnie

Board of Censors (for three years)
Dr. C. M. Burgess

Delegates to Hawaii Medical Association (for two years)
Dr. P. S. Arthur
Dr. R. G. Benson
Dr. Thomas Y. K. Chang
Dr. Fred I. Gilbert
Dr. Edmund Ing
Dr. R. D. Millard
Dr. L. Q. Pang
Dr. Walter Quisenberry

Alternate Delegates to Hawaii Medical Association (for two years)
Dr. Morton Berk
Dr. L. T. Chun
Dr. Carl Johnsen
Dr. Edmund Lee
Dr. Thomas S. Min
Dr. Harold M. Sexton
Dr. C. Y. Sugihara
Dr. William H. Wilkinson
Dr. Shoyei Yamauchi

After a brief message by the new president, Dr. Richard C. Durant, the meeting adjourned at 10:15 for refreshments on the Lanai.

Toru Nishigaya, M.D.
Secretary

Kauai

The October meeting of the Kauai County Medical Society was held at the Kauai Inn, Tuesday evening, October 19. The doctors' wives were invited to this dinner meeting. The floral table decorations by Dr. and Mrs. Masunaga were unusual and beautiful. Those attending were Dr. and Mrs. Masunaga, Ishii, Boyden, Goodhue, Cockett and Drs. Kim, Fujii and Wallis. Guests present were Dr. Richard Lee, Dr. Schilling and Dr. and Mrs. Crowley of Los Angeles.

We were fortunate in having Dr. Richard K. C. Lee as our guest speaker. As a former delegate to the World Health Organization, Dr. Lee spoke of the purpose, the organization and some of the accomplishments of this body.

Dr. Crowley gave a short talk on pheochromocytoma and a case report with slides of a patient operated upon with recovery.

* * *

The regular monthly meeting of the Kauai County Medical Society was held at the Wilcox Hospital, Tuesday evening, November 9, 1954.

The following members were present: Drs. Boyden, Brennecke, Cockett, Fujii, Ishii, Kim, Kuhlman, Masunaga, Wade and Wallis.

Article II, Section I of the By-Laws was changed to read as follows:

> Regular Meetings: Meetings shall be held on the first Tuesday of every month at some designated time and place.

The vote was unanimous.

Dr. Angie Connor discussed three subjects:

(1) Reported on the Kauai Pregnancy Study, reviewing the published report mailed about two weeks earlier.

(2) Announced that the hearing tests were progressing satisfactorily and that the Otologic Clinics would be held November 30 and December 1 with Drs. John Frazer and Webster Boyden acting as consultants.

(3) Certain members of the Heart Society had asked her to get our reaction to a possible survey of rheumatic fever heart lesions—an attempt to find the incidence by investigating designated grades in the public schools.

Dr. Connor was authorized to state that we were interested and probably in favor of such a study being made and would like further information. It was pointed out, however, that due to many factors, the results found on Kauai could not be a true index for the Territory, Oahu especially.

* * *

The regular monthly meeting of the Society was held at the Wilcox Hospital December 7, 1954 at 7:30 P.M. Members present were Drs. Wallis, Wade, Masunaga, Kuhns, Kuhlman, Kim, Goodhue, Fujii, Brennecke and Boyden. Guest—Dr. Quisenberry.

There was some discussion of the decision of Grove Farm Company's refusal to have their plantation physician at Koloa continue to act as Government Physician for that district. A recurring deficit for drugs was the reason for their action. One of the suggestions was that the County be asked to make up the difference between the present drug allowance and the amount actually expended. It is expected that some such arrangement will be made.

Dr. Quisenberry then showed the gastric balloon for collecting cytologic material from those suspected of having gastric cancer. He also discussed the high rate of gastric cancer in the Japanese male population in the Territory. Later, a movie dealing with cancer of the cervix was shown.

WEBSTER BOYDEN, M.D.
Secretary

Maui

The Maui County Medical Society met on Tuesday, October 5, at the Central Maui Memorial Hospital. Present were Doctors Tofukuji, Cole, Sanders, Shimokawa, McArthur, Wong, Kanda, Fleming, Ohata, Haywood, Izumi, H. Kushi, Rockett, Burden by proxy, and Totherow.

A notification from the Vocational Rehabilitation Service requesting a representative of the Medical Society to attend the meeting to be held October 13, 1954 at Baldwin High School to investigate the need for a rehabilitation program on Maui was read. Dr. Haywood moved that Dr. Fleming be appointed to attend the meeting. The motion was seconded by Dr. McArthur and passed unanimously. Dr. Fleming was temporarily absent from the meeting during the action on this motion.

Applications for membership from Doctors Totherow, Archer and Rose were reported on by the Board of Governors recommending favorable action.

The application for membership from Dr. M. D. Boyd was reported by the Board of Governors with the recommendation that his application be deferred for six months for observation and investigation. After some discussion it was moved and seconded that Dr. Boyd's application for membership in the Society be rejected. The vote on this motion was fourteen for and one against.

L. S. ROCKETT, M.D.
Secretary

Umi Makahiki I Hala*

Pathologists' Meeting

The Hawaii Society of Clinical Pathologists held a seminar meeting on the evening of Dec. 1, 1944, at Tripler General Hospital, Farrington Division. Slides from 7 cases previously mailed to the men attending were projected upon a screen and the cases discussed. Following the meeting refreshments were served by the Army. The following men were present: **Lt. Col. C. S. Moran, M.C., A.U.S., Cmdr. E. J. Losli, M.C., U.S.N.R., Dr. Sumner Price, Dr. Thomas Chang, Capt. Henry S. Bernet, M.C., A.U.S., Lt. Col. Tell Nelson, M.C., A.U.S., Major Henry E. Davidson, M.C., A.U.S., Capt. Fred Dick, Jr., M.C., A.U.S., Capt. William Levison, M.C., A.U.S., Dr. E. A. Fennel, Cmdr. O. A. Brines, M.C., U.S.N.R., Cmdr. K. Fowler, M.C., U.S.N.R., Dr. M. Barnes, Dr. I. L. Tilden, Lt. Col. Carl F. Tessmer, M.C., A.U.S.,** and **Major David Adler, M.C., A.U.S.**

Dermatologists' Meeting

The Hawaii Dermatological Society met on the afternoon of December 9, 1944, at 881 South Hotel Street. Ten dermatologic cases were presented and discussed. Present were **Dr. Harold M. Johnson, Dr. Harry L. Arnold, Jr., Major David Musman, M.C., A.U.S., Captain L. H. Rosenthal, M.C., A.U.S., Captain Herbert Lawrence, M.C., A.U.S., Captain Fred Licks, M.C., A.U.S.** (by invitation), and **Captain Irving N. Holtzman, M.C., A.U.S.** (by invitation).

Dr. John Burden Honored

It has recently been announced that **Major John A. Burden, A.U.S.,** formerly physician for Baldwin Packers on Maui, was awarded the Bronze Star by General Joseph W. Stilwell in a ceremony held at C-B-1 Forward Echelon Headquarters.

* Ten years ago. From Volume 4, Number 3, January-February, 1945.

Notes and News

DOCTORS

Elected . . .

. . . officers of the Western Orthopedic Association

President: **Dr. J. Warren White**
Vice President: **Dr. Steele F. Stewart**
Secretary: **Dr. Ivar J. Larsen**
Treasurer: **Dr. B. Allen Richardson**

. . . officers of the Lee Association

President: **Dr. Min Hin Li**
Vice President: **Dr. Edmund L. Lee**

. . . officer of the Honolulu Chinese Junior Chamber of Commerce

President: **Dr. Gail G. C. Li.** Dr. Li also served as President of the Chinese Civic Association.

. . . Fellows of the A.C.S.

Drs. James W. Cherry, Albert K. P. Ho, B. Allen Richardson of Honolulu and **Dr. Harold S. Kushi** of Kahului, Maui, were made Fellows of the American College of Surgeons last December.

Cited for service

Dr. Max Levine, Director of the Bureau of Laboratories of the Territorial Department of Health, was awarded a 40 year certificate for "active service" with the American Public Health Association.

Travellers . . .

. . . around the world

In Berne, Switzerland, **Dr. Steele F. Stewart** addressed the International Society of Orthopedic Surgery and Traumatology. In Beirut, Lebanon, he spoke before the American University. He also delivered addresses at the University of Hong Kong, the Tokyo Army Hospital, and the Osaka Army Hospital.

. . . to New York

Dr. Lyle G. Phillips gave a paper at the 6th Annual Congress of Obstetrics and Gynecology, on observations and statistics at Kapiolani Maternity Hospital between 1947 and 1954.

. . . to Bishop St.

Dr. Claude V. Caver announces the removal of his office to 1154 Bishop Street.

. . . to the A.M.A.

Dr. Homer M. Izumi, as delegate from Hawaii, attended the Interim Clinical Session of the American Medical Association held at Miami, Florida. In Mexico City, he also attended the 11th National Assembly of Surgeons.

. . . to the O.B. Congress

At the 6th American Congress of Obstetrics and Gynecology, **Dr. Frank Spencer** had an exhibit booth for demonstrating a surgical instrument he designed for biopsy of the cervix.

. . . to Chicago

Dr. Ruth Fabritius, former medical resident of Queen's Hospital, has accepted a residency in Ophthalmology at Michael Reese Hospital, Chicago, for the next 6 months. At the termination of this residency, she will be resident in ophthalmology at the Cook County Hospital, Chicago.

. . . to Europe

Dr. and Mrs. L. A. R. Gaspar are back in Hawaii. They toured Sweden. Denmark, Norway, Finland, France, England, Scotland, Ireland, Holland, Belgium and Italy. Welcome back!

Dr. and Mrs. L. C. Beck returned in October from a European visit which included the World Medical Association meeting in Rome.

. . . to Honolulu

Dr. Anthony N. Senese accepted the position as Head of the Department of Anesthesia at Kapiolani Maternity and Gynecological Hospital. Dr. Senese is a graduate of the University of Mexico School of Medicine. He interned at Alexian Brothers Hospital and Holy Cross Hospital in Chicago. He receved his training in anesthesiology at the Presbyterian Hospital in Chicago and at the Chicago Eye, Ear, Nose, Throat Hospital.

Certified

Dr. Harold Sexton received his Pediatric Board certificate in June 1954 and was elected Fellow of the American Academy of Pediatrics in October 1954.

Lecturers . . .

. . . to N.S.C.C.A.

Dr. Nils P. Larsen addressed the Hawaii Chapter of the National Society for Crippled Children and Adults.

. . . to H.B.P.W.C.

Dr. Dorian Paskowitz addressed the Honolulu Business and Professional Women's Club on the subject of "Live Long and Like it."

Called to the service

Dr. Thomas K. Oshiro was called to active duty as a First Lieutenant in the Medical Corps of the Army. After his initial training in Texas, he was assigned to Japan.

United in matrimony

Dr. Ransom J. Arthur married Miss Frances Nickolls of Bedford, New Hampshire, on December 18, 1954. Dr. Arthur is a graduate of Harvard University Medical School. He had 4 years of pediatric residency at the Massachusetts General Hospital and the Children's Medical Center in Boston. At present, he is resident in psychiatry at Queen's Hospital.

Resumed practice

Dr. Shigeo Shinkawa announces his return from 2½ years service with the United States Army and the resumption of his practice at 1473 South King Street. Practice limited to ophthalmology.

Dr. Cyrus W. Loo returned from service with the United States Army in Korea and Japan. He is resuming the practice of dermatology at 1124 Alakea St.

Dr. Robert P. Jay returned from 2 years' active duty with the United States Navy. He is in charge of the Kaneohe branch of the Fronk Clinic, which is slated to open a new building in March.

Island News . . .

. . . from Hawaii

The Hawaii County Medical Society notes with regret the passing of **Dr. Richard Arimizu.** He died on November 10, 1954, following a long illness.

Dr. S. Mizuire has been welcomed back from Chicago where he spent a year studying vascular surgery.

A large number of changes have recently taken place in the personnel serving the Hawaii Island plantations. In order to bring everything up-to-date, the following is the roster of plantation physicians as of December, 1954:

Kohala—**Drs. B. M. Eveleth** and **R. Dimler.**
Honokaa—**Dr. E. D. Willett.**
Laupahoehoe—**Drs. G. Oakley** and **W. Griggs.**
Pepeekeo—**Drs. T. D. Woo, C. Cookingham,** and **D. Poulson.**
Hilo—**Dr. William Bergin.**
Olaa—**Drs. N. Steuermann** and **C. Custer.**
Pahala—**Dr. R. J. Kaufmann.**
Naalehu—**Dr. R. H. Gray.**

. . . from Maui

New members of the Maui County Medical Society include **Dr. William Roy Totherow,** who is associated with **Dr. R. J. McArthur** in Wailuku; and **Dr. Robert Alexander Rose,** Assistant Superintendent of the Pioneer Mill Hospital in Lahaina.

Dr. Dean R. Archer, formerly psychiatrist with the Department of Health on Maui and Hawaii, has accepted a commission for active duty in the Public Health Service.

. . . from Lanai

Dr. Frederick B. Warshauer, who was graduated from the University of Colorado School of Medicine and formerly practiced in Kahuku, Oahu, is now located in Lanai City. He is certified by the American Board of Surgery.

Dr. Jesse I. Knox, Jr. left Lanai to move to San Gabriel, California.

NEWS

Medicolegal Problems

The Seventh Annual Meeting of the American Academy of Forensic Sciences will be held in the Biltmore Hotel in Los Angeles on February 17, 18, 19, 1955.

Stanford Ophthalmology Conference

Stanford University School of Medicine will present the annual postgraduate conference in Ophthalmology from March 21 through March 25, 1955. Registration will be open to physicians who limit their practice to the treatment of diseases of the eye; or eye, ear, nose and throat. In order to allow free discussion by members of the conference, registration will be limited to thirty physicians.

Programs and further information may be obtained from the Office of the Dean, Stanford University School of Medicine, 2398 Sacramento Street, San Francisco 15, California.

Medical Evangelists Postgraduate Convention

Outstanding lectures, panel discussions, and luncheon panel meetings, along with refresher courses, scientific and technical exhibits, and women's activities, will be featured at the 1955 Alumni Postgraduate Convention in Los Angeles February 15 to 17, Dr. William F. Quinn, General Chairman of the Convention's Governing Board, has revealed.

Requests for information about the 1955 APC should be addressed to the Managing Director, Walter B. Crawford, at 316 North Bailey Street, Los Angeles 33, California.

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Dramamine's® Effect in Vertigo

Dramamine has become accepted in the control of a variety of clinical conditions characterized by vertigo and is recognized as a standard for the management of motion sickness.

Vertigo, according to Swartout, is primarily due* to a disturbance of those organs of the body that are responsible for body balance. When the posture of the head is changed, the gelatinous substance in the semi-circular canals begins to flow. This flow initiates neural impulses which are transmitted to the vestibular nuclei. From this point impulses are sent to different parts of the body to cause the symptom complex of vertigo.

Some impulses reach the eye muscles and cause nystagmus; some reach the cerebellum and skeletal muscles and righting of the head results; others activate the emetic center to result in nausea, while still others reach the cerebrum making the person aware of his disturbed equilibrium. *Vertigo may be caused by a disease or abnormal stimuli of any of these tissues involved in the transmission of the vertigo impulse, including the cerebellum and the end organs.*

A possible explanation of Dramamine's action is that it depresses the overstimulated labyrinthine structure of the inner ear. Depression, therefore, takes place at the point at which these impulses, causing vertigo, nausea and similar disturbances, originate. Some investigators have suggested that Dramamine may have an additional sedative effect on the central nervous system.

Repeated clinical studies have established Dramamine as valuable in the control of the symptoms of Ménière's syndrome, the nausea and vomiting of pregnancy, radiation sickness, hypertension vertigo, the vertigo of fenestration procedures, labyrinthitis and vestibular dysfunction associated with antibiotic therapy, as well as in motion sickness.

Any of these conditions in which Dramamine is effective may be classed as "disease or abnormal stimuli"* of the tissues including the end organs (gastrointestinal tract, eyes) and their nerve pathways to the labyrinth.

Dramamine (brand of dimenhydrinate) is supplied in tablets of 50 mg. and liquid (12.5 mg. in each 4 cc.). It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.



The site of Dramamine's action is probably in the labyrinthine structure.

*Swartout, R., III, and Gunther, K.: "Dizziness:" Vertigo and Syncope, GP *8*:35 (Nov.) 1953.

NOT ARTHRITIS BUT ARTHRALGIA...

If the patient complaining of aching joints is a woman between 37 and 54 years of age, it is highly possible that she is suffering from arthralgia rather than arthritis.[1] It has been estimated that arthralgia occurs in about 40 per cent of women with estrogen deficiency, and is exceeded in frequency only by symptoms of emotional or vasomotor origin.[2] In fact, arthralgia may be as indicative of declining ovarian function as the classic menopausal hot flushes.

Arthralgia, however, is just one of a vast number of distressing but ill-defined symptoms that may be precipitated by the loss of estrogen as a "metabolic regulator." Other good examples are insomnia, headache, easy fatigability, and tachypnea.

Because these symptoms sometimes occur years before or even long after cessation of menstruation, they are not always readily associated with estrogen deficiency, and the tendency may be to treat them with medications other than estrogen. Obviously, sedatives and other palliatives cannot be expected to produce a satisfactory response if an estrogen deficiency exists. Only estrogen replacement therapy will correct the basic cause of the disorder.

"Premarin" is an excellent preparation for the replacement of body estrogen. In "Premarin" all components of the complete equine estrogen-complex are meticulously preserved in their natural form. "Premarin" produces not only prompt symptomatic relief but a distinctive "sense of well-being" which is most gratifying to the patient.

1. Greenblatt, R. B., and Kupperman, H. S.: M. Clin. North America *30*:576 (May) 1946. 2. McGavack, T. H., in Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc., 1953, p. 225.

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INTER-ISLAND NURSES' BULLETIN

Official Publication of the Nurses' Association, Territory of Hawaii

LEONA R. ADAM, *Executive Secretary*, Honolulu

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PRESIDENT'S MESSAGE

With the lovely Christmas season behind us and another New Year ahead, we are renewing plans for the growth and development of our Association. The American Nurses' Association, of which we are a constituent part, aims to provide better nursing care for the people of our nation by improving nursing practice and the welfare of individual nurses. We can help to raise the standards of nursing service in Hawaii by actively participating in the work of the committees set up to define the functions, standards of practice, qualifications and minimum conditions of employment for professional nurses in the Islands. Let us hope that before the end of this year we shall have Territorial standards for nursing that are sound and reasonable and sincerely aimed at bettering the nursing services offered to the people of our community whom God has entrusted to our care.

SISTER MARY ALBERT

ALCOHOLISM—A PROBLEM FOR INDUSTRY*

ELIZABETH D. WHITNEY, EXECUTIVE DIRECTOR
BOSTON COMMITTEE ON ALCOHOLISM

A problem that involves the customs and thinking of a large number of people for centuries is not going to be eradicated over night, nor is it going to be solved in a few short years. Still, in recent years a notable change in public attitude has taken place regarding alcoholism, the nation's fourth greatest public health problem. This change has been due to the efforts of a few groups who, during the past fifteen years, have concentrated in this field. As a result of their work, alcoholism has finally come to be recognized as an illness, and its treatment placed in the field of medicine.

Many groups, including twenty-six state bodies, are now concerned with the study and treatment of alcoholism. However, the three major influences which have initiated, guided, and perhaps had the greatest effect to date are (1) Alcoholics Anonymous, with its thousands of dramatic recoveries which have received broad publicity through its tremendous emotional appeal; (2) the scientific research carried on at Yale University, which has found its way into thousands of scientific papers and into other educational institutions; (3) the National Committee on Alcoholism and its fifty-six affiliated community committees, which were established to educate the public about alcoholics and the nature and extent of alcoholism.

Each of these groups has different functions which are all vitally needed for establishing public cooperation.

1. *Alcoholics Anonymous*, the largest group, has successfully proved that alcoholics can recover. This group is made up entirely of alcoholics who have voluntarily sought help from members of this informal fellowship. Its sole purpose is to help alcoholics recover through its program of twelve suggested steps. It does not endorse or oppose anyone and it is supported entirely by its members.

2. *The Yale Center of Alcoholic Studies* has shown that medicine can help the alcoholic and that there are numerous medical aspects of the problem. The work of this group, which started some fifteen years ago in the Department of Applied Physiology at Yale, has gathered, studied, analyzed and recorded data pertaining to

* Reprint from *Health at Work*, A Publication for the Industrial Nurse. Liberty Mutual Insurance Company.

the problems of alcohol and alcoholism and has carried out an extended laboratory program of research.

The first clinic for the treatment of alcoholics established at Yale and the work there has indicated the role of the medical profession in the treatment of alcoholism. The Yale group has publicized its findings in the periodicals, lectures and through a summer session attended mainly by persons working in the field of alcoholism.

3. *The National Committee on Alcoholism* and its affiliated local committees were formed to spread the news that alcoholics could recover and to give information on effective types of treatment and where such treatment facilities were located. A number of these committees have also inaugurated counseling and guidance services, through which they demonstrate daily how the alcoholic can be induced to seek help and that such help is effective.

Through these means the public is slowly acquiring the knowledge that alcoholism is a disease of major importance, that the alcoholic can be rehabilitated, and that the solution of this problem is a public responsibility. The committees accumulate and distribute scientific literature on alcoholism and use the press, radio, television, public platform and public conferences as additional means of public education. They are not concerned, however, with the wet-dry issues. More recently their activities have expanded to include giving counsel and guidance to community and state organizations, which are being formed all over the country to assist in combatting this disease.

A few years ago doctors and hospitals would not accept alcoholics as patients because doctors and hospital administrators, like the average citizen, believed alcoholism to be a moral issue and not an illness requiring skilled medical attention. Now, as a result of the recoveries in Alcoholics Anonymous, and of the scientific findings at Yale and more recently at other universities, and through the educational campaigns of the National Committee on Alcoholism and its affiliates, hundreds of hospitals are opening their doors to sick alcoholics. In 1950 the American Medical Association acknowledged for the first time that alcoholism is a medical responsibility, and a committee has been set up within that body to deal with the problem.

Why Alcoholism Concerns Industry

While no one can state accurately the total number of alcoholics, available figures indicate that out of some sixty-five million Americans who use alcoholic beverages, about four million are alcoholics, and of these about half are employed in industry and business.

Recent studies at Yale covering more than two thousand male patients treated over a period of time and seen in nine different clinics in different parts of the country show that (1) more than eighty per cent were under fifty years of age, one out of four was under thirty-five; (2) over half were married and supporting a family; (3) at least seven out of ten had held jobs involving skills or responsibility; (4) nearly sixty per cent were known to have held steady employment on one job for at least three years, twenty-five per cent for at least ten years.

The Problem Drinker in Industry

Assuming that there are two million alcoholics employed in industry and that there are some thirty-five million industrial workers in this country, it follows that on the average there are nearly six alcoholics among every one hundred employees. The alcoholic may be found in any department and on any level of seniority, from the top executive to the unskilled worker.

He is generally a man with more than average ability with respect to the position held, and his alcoholic tendencies have been developing over a period of from ten to twelve years. Generally he is a capable and responsible worker when he is not suffering from the after-effects of excessive drinking. For these reasons, at least in the early stages, his alcoholism has been covered up by his family, by his fellow workers, by foremen and by management itself, in the mistaken belief that they are helping the man by so doing. They do not realize that for him alcoholism is a progressive disease which, unless given the proper help, may eventually lead to his dismissal.

Unfortunately this condition reaches its peak and is the cause for dismissal at about the time when the man is approaching his peak of productivity. If the disease is to be arrested it must be recognized in its early stages and the employee given the proper kind of help at that time. It is a well-known fact that the alcoholic does not respond to warnings or threats of dismissal any more than a person suffering from any other illness does. Constructive approaches require a knowledge of the progressive nature of alcoholism and treatment facilities where the alcoholic may go for help in an atmosphere of sympathetic understanding.

How Industry Is Solving the Problem

There are a number of companies that have pioneered in two ways: first, in recognizing the fact that there were problem drinkers among their employees; and second, in inaugurating a plan to do something about it. None of these companies uses exactly the same plan, yet all have met with success. Four companies have publicly stated that they are successfully rehabilitating alcoholic employees: Consolidated Edison of New York, Allis-Chalmers Manufacturing Company, E. I. DuPont de Nemours, and Eastman Kodak Company. In these four companies the rehabilitation program is under the direction of the medical department.

Allis-Chalmers reports a study of seventy-one cases of problem drinkers among their employees. After eight months of using modern methods of treatment the report shows disposition of these

cases as follows: one had died; nine had left the employ of the company, either of their own volition or because they were discharged, fifty-one were working and apparently free from their alcoholic difficulties and there were ten whose disposition was undetermined at the time of the report.

These alcoholics were discovered as a result of a study of absenteeism cases, of which ten per cent were found to be having an alcoholic problem. Before treatment was started more than eight per cent of the working time of the seventy-one employees studied was lost through absenteeism. At the time of the report this figure had fallen to three per cent, which was below the rate of all other absentees. Of these seventy-one employees over fifty were between thirty and fifty-five years of age, fifty-five had been with the company more than five years and thirty-two had been with the company ten years or more.

To treat alcoholics successfully the services of a physician, a psychiatrist, a psychologist and a social worker should be available. In addition, in large companies the help from the legal, housing, welfare, veteran's counselor, mutual aid, credit union, and recreation departments will all be found useful. While some alcoholic cases are relatively simple to treat, others may require a combination of these facilities. In any event, a medical diagnosis and study of the individual problem drinker is advisable.

Both large and small companies will find it advantageous to use community facilities. The Eastman Kodak Company, for example, gets substantial help from its local Committee for Education on Alcoholism, local hospitals and members of Alcoholics Anonymous.

Some Reasons Why People Drink

When anyone becomes interested in problem drinkers usually the first question that comes to mind is, "Why do they drink?"

If the true cause or reason can be discovered in any ailment, usually the ailment can be treated, improved or cured. The same is true with the problem drinker. If we know what is troubling him, we are well on the way toward helping him solve his problem. If a person does not find alcohol important, he has no particular reason to defend his drinking, so he would probably be called a social drinker. The reasons given for excessive drinking are all basically alike. They are commonly given as escape from living conditions, release from daily restrictions, lack of social and recreational interests, escape from frustration brought on by inner conflict, escape from worry, or fear of not being able to face life without alcohol.

These and many other reasons have brought more than 3,000 alcoholics to the Information Center of the Boston Committee on Alcoholism in the past six and a half years for help with their problems. These men and women represent a cross section of the community and come from all walks of life.

Alcoholism cripples the harmony of home, society, industry and business. In its cloak of deception it steals, inch by inch, all of man's possessions and robs him of his strength and dignity.

There are tools with which to rehabilitate and there are educational programs to prevent further development of this disorder. The recognition of alcoholism as an illness among industrial employees, to be treated on a par with other illnesses, is not only a challenge to our industrialists, it is the duty of every citizen who would meet a major problem squarely in an endeavor to improve the health of our nation.

Suggestions for Industrial Control of Alcoholism

As stated in the preceding article, efforts to control excessive drinking should be based on the premise that alcoholism is a medical problem. There must be frank recognition of the fact that the alcoholic, like the diabetic or the cardiac, is a sick person and deserves the same understanding and consideration as the victim of any serious ailment. Proper referral and prompt treatment are essential if the problem drinker is to be returned to a normal life.

Experience shows that the excessive drinker is inclined to be a less productive worker, has a greater tendency to be absent from work and may be involved in more accidents when on the job than the employee who limits his use of alcoholic beverages. Although industry does not concern itself with the employee's privilege to drink as regards his personal life, when his conduct is affected to the extent that he is no longer an efficient worker, it may be industry's prerogative to enter the picture.

Some organizations have found it advisable to maintain an alcoholic counselor who, having been rehabilitated himself, has a thorough understanding of the chronic drinker's problem. The average industrial plant would find it economically impossible to employ a special counselor for this purpose but the industrial nurse, who has won the confidence of management and employees alike, may logically be expected to participate in a similar capacity. By familiarizing herself with the characteristics of alcoholism and methods of control and acquainting herself with various commu-

nity services the nurse should be able (1) to give management valuable guidance in evaluating the problem and setting up a suitable program, (2) to counsel the problem drinker most beneficially, (3) to coordinate the industrial program with the activities of local agencies.

Industrial control of alcoholism being in the formative stage, each industry will find it expedient to develop its own plan, based on available facilities in the industry and the community. Success of the program will depend largely on management participation and cooperation of medical, personnel, and supervisory personnel.

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PUBLIC HEALTH NURSES SECTION

KAZUE MC LAREN, R.N.

"Our Future in Economic Security" was the subject of the program of the Public Health Nurses Section, NATH, during the annual convention. Speakers were Mr. Charles Kendall, Executive Secretary of H.G.E.A.; Dr. Thomas Ige, Economist at the University of Hawaii; Miss Leona R. Adam, Executive Secretary of NATH; and Mrs. Alice Scott, Chairman of the Public Health Section, Nurses' Association, District of Oahu.

The speakers outlined the history of the economic security program in nursing, the procedures involved in planning for a sound economic security program, especially among civil service employees and the role of the section toward this goal.

At the section business meeting, the delegates voted to work toward this goal. It was decided that committees be appointed on each island to facilitate meetings and investigations.

The following committee have been assigned to each district by the section's Executive Committee:

Study Committee (to make research about the various aspects of economic security) to Oahu
F. S. & Q. (to work on the Standards of employment) to Maui
Rules and Revisions to Hawaii
Program to Kauai

Officers for the current year are:

President.....Miss Winnifred Golley
Vice President.....Mrs. Josephine Duvachelle
Secretary.....Mrs. Emelia Centeio
Members-at-large.....Mrs. Mabel Snyder
Miss Mamie Murakami

NEW OFFICERS

Educational Administrators, Consultants and Teachers Section

Chairman.....Miss Mary Neal
First Vice Chairman.....Mrs. Cynthia Wolfe
Second Vice Chairman.....Miss Evelyn Lau
Secretary.....Miss Marie Sharp
Members-at-large.....Mrs. Anne Camara
Mrs. Clara Ishikawa

General Duty Section

Chairman.....Mrs. Joan Shelton
First Vice Chairman.....Mrs. Leila Miyamoto
Second Vice Chairman.....Yasuko Ideguchi
Secretary.....Ramona Kimura
Members-at-large.....Tatsuko Uehana
Sumiko Henna

HIGHLIGHTS—HOUSE OF DELEGATES SESSION, 1954

October 13

Reports of various groups and committees were given in the first session of the House of Delegates.

The Membership Committee emphasized the ANA definition of associate membership which is as follows:

> Associate membership is designed for those retired or inactive nurses whose incomes are thus curtailed, but whose interest and enthusiasm is undiminished as valuable participating members in their professional organizations. Nurses employed in any type of position benefit from the programs of their professional organizations and as actively employed people can reflect their needs and wishes through active membership. Thus, nurses employed as physiotherapists, health educators, or any other type of employment for more than thirty days of the calendar year are ineligible for associate membership.

The following recommendations of the Nursing Information Committee were accepted:

1. All media which may be utilized to disseminate nursing information should be contacted. Many of the racial newspapers, and weekly and monthly publications have a good following of readers who are not presently being reached.

2. Organize public relations committee on the district levels. Much newsworthy activity is being bypassed because the information does not reach this committee in time for the proper timing so necessary in publicity work.

3. Personal contacts should be made with city editors, radio and television station managers, to establish proper rapport which is of paramount significance in maintaining an effective public relations program.

October 14

Mr. Gilbert, representative from HMSA, discussed the advantages of HMSA insurance and urged nurses throughout the Territory to consider membership through the Territorial Nurses' Association. Applications are acted upon in November and May.

Miss Lucile Otto spoke of the scrapbook on nurses and nursing in the Territory which she has been bringing up-to-date this year. This fascinating book is available in the NATH office for anyone interested.

Accepted recommendations of the Finance Committee:

a. That $2,000 of the reserve fund be invested with the advice of Bishop Trust.

b. That the duties of the treasurer in the by-laws be amended by the addition of:
After the board approves attendance at any meeting called by the American Nurses' Association and for which ANA will pay travel expenses but for which NATH must pay living expenses, the treasurer may advance payment for plane fare to be reimbursed by ANA and living expenses at the rate of $15 per day.

c. The budget of $10,620.78, as recommended by the Finance Committee, was revised and accepted at $10,390.78.

Moved that a special committee representing all the districts be formed to study the budget and recommend solutions for meeting the amount accepted.

Moved that unless the committee arrived at a better solution that the budget be prorated to the districts according to the formula used last year.

Moved that the by-laws be amended as recommended and circulated by the committee with a few minor changes in wording.

Invitation—Kauai extended an invitation to hold the 1955 convention on that island. This was enthusiastically accepted.

Resolutions passed:

1. Resolution of appreciation to all those who contributed to the success of the convention.

2. WHEREAS there is a need to develop leadership in the association, and WHEREAS there is a need for a planned training program to fulfill this need, and WHEREAS there are available in the community people well qualified to conduct such a program, be it hereby therefore, RESOLVED that the Nurses' Association, Territory of Hawaii, Inc., encourage and assist the districts to plan and carry out a program for leadership training.

3. WHEREAS the members of our association have learned of the death of Mrs. Lillian B. Patterson who has served as first vice president of the American Nurses' Association, and WHEREAS Mrs. Patterson has made great contribution to the nursing profession, and WHEREAS the Nurses' Association, Territory of Hawaii, Inc., feels a deep sense of loss, now therefore be it RESOLVED that we express to her husband, Mr. Claude Patterson, our deep sympathy in his loss and our appreciation of the work which she has done both nationally and internationally for nurses and nursing.

HIGHLIGHTS OF NATH BOARD MEETINGS

October 12, 1954

Heard recommendations submitted by various committees. These were accepted and referred to the House of Delegates.

Discussed the probability of the introduction of legislation for the centralization of occupational licensing, and the need for NATH to be prepared to take action. It is essential that the Board for the Licensing of Nurses retain its autonomy and its special fund.

November 19, 1954

Moved appointment of special committee for study of solutions for meeting the budget which can meet for a full day on Hawaii in February. Expenses of members to be paid by the association. Each representative is to form a working committee on her own island to study the situation before the meeting. Chairman to be elected when the committee meets.

Moved to abide by decision of Hawaii League for Nursing Board in relation to legislation for nursing scholarships.

Moved to correspond with American Buyers Service, Inc. relative to establishing a mail order buying service for members of the Association. This service offers a great variety of items of good brands at greatly reduced costs.

Set up new committees and committee chairmen for 1955.

Moved that a sub-committee of the Professional Counseling and Placement Service Committee study the problems of the older nurse.

Accepted report of the Economic Security Committee (composed of Section Chairmen).

Several sections at their annual meetings in October accepted in principle the ANA suggested survey questionnaire on employment conditions. Between the meeting of the committee in November and the next meeting in March the chairmen of sections interested in the survey are to meet with their executive committees to determine what kind of information they desire. This will then be pooled in the committee and a survey questionnaire be set up to send to Directors of Nursing throughout the territory.

The Industrial Nurses Section are working on their own survey form which will be sent to individual industrial nurses. The Public Health Section is very active. They have accepted the public health nurses' functions as set up by the ANA

Public Health Section. The Maui public health nurses are studying and attempting to establish standards in public health nursing. A committee on Oahu is serving as a fact finding committee which is an enormous task. The information collected by this committee will be available to the Economic Security Committee and through this to other sections needing the same type of information.

The Educational Administrators, Consultants and Teachers Section has set up functions and is working on standards and contacting mainland hospitals regarding employment conditions for members of this section.

The Institutional Nursing Service Administrators Section has divided responsibilities. The Kauai group are studying minimum employment conditions, Maui is studying function standards and qualifications for administrators, and Oahu is working on minimum employment conditions for supervisors.

WHAT COMPLETE NURSING CARE IN GERIATRICS MEANS TO ME*

I am so happy that I have come to the Practical Nursing School for it has taught me so many good and useful things—things with which I can help others less fortunate than I. Geriatrics means so much to me because my father had a cerebral hemorrhage a few years ago, and I know what it is to have someone close just waste away in front of your eyes. I realize now it needn't have been had I known what I now know, but then it is never too late. Maybe he doesn't have much time left for he shows symptoms of a person pretty far gone, but I pray God that I will have a chance to apply some of my knowledge gained to make his remaining days as comfortable and happy as possible. Help is short-handed at home so he doesn't get the attention he deserves, but how happy he would be if I could take his hands, smile and talk to him though he doesn't seem to understand, and massage his emaciated body soothingly as Miss Sorg† taught us. To clean his failing eyes of pus with boric acid, wash his mouth frequently with mouth wash for I noticed he had a difficult time in swallowing and always kept his saliva in his mouth—all this which I didn't understand at that time makes me know now that there was so much I could have done to help him.

Besides being a paraplegic, he has a failing heart so the doctor has restricted salt in his diet. I am sure that by using a salt substitute and other seasonings as we were taught in class, I can prepare food that he will enjoy. It means so much to a helpless elderly person to be made comfortable and happy—to be treated as an individual. He is beyond the stage where we can make him feel useful, but we can certainly make him feel wanted.

His failing eyesight has sharpened his hearing and I know that he would really appreciate some of the old-fashioned songs on a phonograph. He has lost his speech and so he is left alone most of the time, but I know his face would light up with happiness if someone would talk to him. He spends so much of his time just lying in one position, I think how painful it must become. Changing his position would help his aching body I know and would have prevented the terrible bedsore he has had for so long. I pray God I won't be too late. If it is His will that he must go before I finish school, I know that my learning has not been in vain for there are so many other elderly people that I would be able to comfort and give good nursing care. No matter where, in a home or in a hospital, elderly people really appreciate a nurse's kind words, gentle handling, and confident care.

* Miss Dorothy S. Iwaishi, whose home is on Maui, entered the Practical Nursing School as a member of the fall class of 1954. This paper was written as her geriatric project in the Home Nursing Course.

† Paula Sorg—Physical Therapist, Dept. of Health.

HAWAII—KAUAI—MAUI—PLEASE NOTE

Dear Professional Nurse:

The some 300 applications received each year by the Practical Nursing School indicate that the proportion of applicants from our neighbor islands is decreasing steadily.

Efforts toward recruitment there have consisted of yearly visits to the high schools by representatives of the professional schools discussing both professional and practical nursing, and visits and talks by staff members of the Practical Nursing School, as well as information on the school as distributed by the D.P.I. to all high schools for use in Vocational Guidance.

We must use additional means to attract sufficient acceptable candidates.

We need both men and women—not only high school graduates but older persons as well. We find the middle-aged men and women among the most successful and acceptable of our graduates.

Recruitment in high schools has not touched this group. We need your help and co-operation.

In your daily contacts with volunteer workers and nurses' aides in the hospital as well as with men and women in other types of work, you may find opportunity to give information about the course.

We find that the interest in nursing which prompted students to enter the school has usually been inspired or encouraged by some nurse in the home community.

May we count on you to help?

MARJORIE ELLIOTT
Director

DISASTER COMMITTEE, NURSES' ASSOCIATION, DISTRICT OF OAHU

The Disaster Committee of the Nurses' Association, District of Oahu, has established committee purposes and functions, and has made the following recommendations to appropriate nursing groups. The committee members are Miss Virginia Jones, Miss Alison MacBride, representative from NATH; Mrs. Alice Scott, Mr. Lawrence Katsuyama, and Miss Mary V. Neal, Chairman.

Purposes:

1. To insure quality nursing in national defense.
2. De-emphasize the "shortage of nurses."
3. Endorse continued research in nursing functions.

Functions:

1. To make recommendations to appropriate groups in order to achieve objectives of the program.
2. To establish and evaluate criteria to determine:
   a. Availability of the nurse.
   b. Essentiality of the position.
3. To cooperate with civil and military groups in planning for nursing in the national defense.

Recommendations Made to Appropriate Groups

1. A formal letter to the "Careers Committee" of the Hawaii League for Nursing has requested their cooperation in developing means for recruiting more students for schools of nursing. In order to be prepared for national defense it is essential that the nursing strength of the country be maintained. Recruitment of students for schools of nursing is the responsibility of the nursing profession, allied groups, and the public.

2. It is requested that the program committee of the Nurses' Association, District of Oahu, either develop through their own resources, or request the Hawaii League for Nursing to aid in developing, a year-round program, giving newer trends in nursing, including the latest medication and treatments. This refresher course should be started in the very near future. All active and inactive licensed registered professional nurses and licensed practical nurses should be invited to attend these classes.

3. The Disaster Committee endorses the Economic Security Committee of NATH in their promotion of sound personnel policies as a means of stabilizing local nursing service. It is imperative that personnel policies be designed to help make working conditions attractive, and that salaries be comparable to those paid to industrial production workers.

4. It is also requested that the program committee of the Nurses' Association, District of Oahu, develop a program for one of its monthly meetings on a topic of disaster nursing, such as a shelter activity.

5. It is further recommended that every nurse have a current Red Cross First Aid Certificate.

6. It is also requested that the Board for the Licensing of Nurses make available to our schools of nursing the material on integration of concepts of nursing in national defense into the basic professional program for nurses prepared by Major Margaret E. McKenzie.

Disaster Nursing Availability Statistical Report

	PROBABLY AVAILABLE	PROBABLY NOT AVAILABLE
Hawaii:		
Professional nurse total	47	10
Practical nurse total	62	14
Kauai:		
Professional nurse total	22	10
Practical nurse total	27	7
Maui:		
Professional nurse total	33	4
Practical nurse total	49	12
Molokai:		
Professional nurse total	8	0
Practical nurse total	4	1
Lanai:		
Professional nurse total	1	0
Practical nurse total	0	0
Oahu: City of Honolulu		
Professional nurse total	359	58
Practical nurse total	203	38
Rural Oahu		
Professional nurse total	67	17
Practical nurse total	60	14

MARY V. NEAL, R.N.

BAZAAR

MARY NEAL

Save This Date! — February 5, 1955! — The Date of the Nurses' Association, District of Oahu, Annual Bazaar!

Saimin! Barbecue! The orchid plant you have always wanted! These and many more delightful treats will be available at the Nurses' Bazaar, Queen's Hospital grounds, February 5, 1955, from 9:00 a.m. to 10:00 p.m. The 1955 Nurses' Bazaar will again provide food and fun for the whole family! So, reserve this date today! February 5, 1955! Annual Bazaar, Nurses' Association, District of Oahu!

General Chairman, Mrs. Esther Stubblefield, has announced that plans for the 1955 Bazaar are well under way. Assisting as co-chairmen are Mrs. Leila Miyamoto, 1st co-chairman, Queen's Hospital, Tel. 5-5981; and Mrs. Emilia Centeio, 2nd co-chairman, Kapahulu Health Center, Tel. 7-1921.

General committee responsibilities of the chairmen, directed by the following sub-committee chairmen, are:

Mrs. Stubblefield:

Publicity—Miss Mary Neal, chairman, Red Cross—bu. 5-2571.

Clothing—Mrs. Mabel Snyder, chairman, Lanakila Health Center—bu. 8-6481.

Public address system—Mrs. Joan Shelton, chairman, Children's Hospital—bu. 5-4563.

White elephant—Miss Ramona Kimura, chairman, Kuakini Hospital—bu. 6-2236.

Scrip—Miss Mamie Murakami, chairman, Lanakila Health Center—bu. 8-6481.
Plants—Mrs. Clara Ishikawa, chairman, Cancer Society—bu. 6-2336.
Donations—Mrs. Lillian Mau, chairman, Lanakila Health Center—bu. 8-6481.

Mrs. Miyamoto:
Construction; Concessions; Clean-up.

Mrs. Centeio:
Saimin—
Barbecue—Mrs. Jean Sison, chairman.
Hot dogs and sushi—Mr. Lawrence Katsuyama, chairman, Kuakini Hospital.
Soda water and ice cream—Mrs. Eleanor Fern, chairman, Leahi Hospital.
Laulau—Mrs. Rachel Kong, chairman, Hale Mohalu.
Doughnuts and coffee—Mrs. Dorothea McClintic, chairman, Leahi Hospital.
Baked goods—
Jams and jellies—Mrs. Haruyo Yoshioka, chairman, Kapahulu Health Center.

Nurses who would like to assist with the Bazaar project may contact the committee chairmen, or sub-committee chairman listed above. Donations of volunteer assistance, baked goods, jams, jellies, white elephants and so forth will be gratefully accepted.

Hope to see you and your family at the Nurses' Bazaar, Queen's Hospital grounds, February 5, 1955, from 9:00 a.m. to 10:00 p.m. There will be FUN, FOOD, and BARGAINS for all!

LETTER FROM WASHINGTON, D. C.

Abstract from letter from Aiko Yano, formerly supervisor in pediatrics at Kuakini Hospital, now employed at Children's Hospital, Washington, D. C.

I am enjoying my work here at Children's very much. It is an all together different type of work here. I'm with the O. P. D. and am in charge of the skin clinic. It is very interesting to meet all kinds of people. I couldn't understand some of them. Their Southern drawl gets me. By the time I get back to Honolulu I'll be talking like them.

Miss Joe Blaz of St. Francis Hospital is working here at Children's in the Post Polio ward. Small world isn't it? I met Miss Alice Shida, Miss Ikeda and Miss Kuwamoto in New York.

Please give my regards to all the nurses and I'll try to attend all the meetings held here in D. C.

SCHOLARSHIP FOR GRADUATE NURSE EDUCATION

1. Territorial until June 30, 1955 for locally born nurses. Write to Board for the Licensing of Nurses, 510 South Beretania Street, Honolulu.
2. Kate Marion Atherton Scholarship Fund (Honolulu YWCA).
3. Chamber of Commerce of Honolulu, Public Health Committee. For graduate work in the field of health.
4. Honolulu Community Chest. Preferably for graduate work not available locally. Applications must be in by end of February.

Call 6-8630, or write the Nurses' Association, Territory of Hawaii, Inc., 510 South Beretania Street, Honolulu, for further information regarding scholarships.

JOB OPPORTUNITIES

1. *Nursing Field Representatives, American Red Cross*
We have been advised of a continued need for candidates for the above positions in the Eastern and Midwestern Areas. The Eastern Area comprises 16 states from Maine to Virginia on the Atlantic Coast plus the states of Indiana, Kentucky, Ohio, Vermont, West Virginia and the District of Columbia. Application for appointments in this area should be made to:

   Earl Herbert, Personnel Director
   Eastern Area, American Red Cross
   615 North St., Asaph Street
   Alexandria, Virginia

   The Midwestern Area includes 16 midwestern states exclusive of Ohio and Indiana. Application should be made to:

   Leslie This, Director, Personnel Service
   Midwestern Area, American Red Cross
   4050 Lindell Boulevard
   St. Louis 8, Missouri

2. *Technical Supervisor, Blood Program, American Red Cross*
Candidates for this position are needed in the Midwestern Area.
3. *Nurses needed in Panama Canal Zone*
Applications are now being accepted for positions in nursing in hospitals in the Panama Canal Zone. Staff nurse salary is $4,262.50 per year and Head Nurse salary is $5,256.25. These salaries include a 25 per cent differential for tropical service.
4. *Nurses needed in Guam*
Staff nursing positions in hospitals in Guam pay $3,850 per year, Head Nurse, $4,712.50, and Director of Nursing, $5,720. These salaries include a 25 per cent Territorial post differential. Employment is for a two year period.
5. There are often calls for nurse anesthetists, especially on the islands other than Oahu.
6. Almost anything you want on the mainland.

Further details may be obtained from your Professional Counseling and Placement Service, 510 South Beretania Street, Honolulu, phone 6-8630.

NEWS

In November the Executive Secretary, Leona R. Adam, attended an ANA workshop for counselors held in Seattle, Washington. A report of this meeting has been sent to all NATH officers and to each district.

* * *

John Kennedy, M.D., Director of Medical Service, Guam, visited the NATH office to discuss the nursing personnel needs of Guam. He is interested in having nurses from Hawaii apply.

* * *

The Alaska Nurses' Association each year sells tickets for prizes. One year the grand prize was a car; this year it was a round trip to Hawaii. The prize was won by Mr. Lewis E. Simpson, so he, his wife, and two chil-

dren came to Hawaii. They were greeted at the airport with leis from NATH by Miss Karen Tanaka, Publicity Chairman. Miss Tanaka and Miss Vivian Zane later took them around the island. Another day they were shown the Mabel Smyth Building and met a few of our members. They were a very charming family and it was interesting meeting them.

NEW HANDBOOKS AVAILABLE

The Public Health Service, of the U. S. Department of Health, Education, and Welfare, announces publication of "How to Study Nursing Activities in a Patient Unit," a manual to aid hospitals in making better use of personnel. The publication offers a method by which hospitals of all sizes may determine how nursing personnel time is distributed between duties requiring nursing skills and those which could be performed by other hospital personnel. The purpose of the study is to give nurses more time to be with patients. Nursing personnel themselves have an opportunity to take part in the study and to analyze their own activities.

Prepared by the Division of Nursing Resources under the direction of Margaret G. Arnstein, R.N., Chief, the manual reflects the Public Health Service's concern with finding ways of making more nursing care available to the public through the conservation and more effective use of scarce nursing skills.

The manual may be purchased for 25 cents per copy from the Superintendent of Documents, Government Printing Office, Washington 25, D. C.

* * *

A handbook, "Mobilizing Your Personal Resources for Better Patient Care," prepared by the Office of Defense Mobilization Health Resources Advisory Committee, is available from the Superintendent of Documents, Government Printing Office, Washington 25, D. C., at 40 cents per copy.

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SALMONELLA

(Continued from Page 211)

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(Continued from Page 237)

Miscellaneous

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Kaye, Sidney. *Handbook of emergency toxicology.* c1954. (gift of publisher).

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BOOK REVIEWS

(Continued from Page 236)

Furthermore the Medical Examiner system, backed by all experts in the field and actively campaigned for by popular mystery story writer Earle Stanley Gardner, has been used in New York City for many years both under Dr. Norris, considered by many the father of the Medical Examiner system, and under Dr. Gonzales and his staff. This system allows for an accurate and authoritative non-political exposition of that area where the fields of medicine and law overlap.

This is a very excellent book and is recommended to men in any field of medicine wherein they may run into legal problems which nowadays would appear to be anyone who practices medicine.

Physically the book is well bound and the print is large and legible.

W. Harold Civin, M.D.

Elements of Pediatric Anesthesia.

C. R. Stephen, B.Sc., M.D.C.M., D.A., 109 pp., illustrated, Price $3.50, Charles C. Thomas, 1954.

This monograph is beautifully and concisely written by one of the foremost anesthesiologists. Emphasis is placed upon the anatomic and physiologic considerations which are of paramount importance in the safe anesthetic management of infants and children. Well selected tables should prove a helpful reference in selection of premedication dosage and transfusion volumes according to developmental requirements. The book is not a technical manual, but primarily a guide to sound principles without which the difficulties encountered during anesthesia administration might lead to disaster. Thus, it should be found stimulating and of interest by pediatricians, surgeons and anesthetists alike. The chapter on asphyxia neonatorum should be read by all members of an obstetrical team.

Carl E. Johnsen, Jr., M.D.

The Doctor Writes.

By S. O. Waife, M.D., F.A.C.P., 175 pp., Price $3.75, Grune & Stratton, Inc., 1954.

A compilation, from recent medical literature, of unusual literary efforts by physicians—chiefly on medical topics. Most of the selections are good, and some are excellent—if you have read them before you'd enjoy having them around to read again, and if you hadn't read them before, you'd be glad of the chance. Joseph Klauder's *Sherlock Holmes as a Dermatologist* or John Todd's *The Superior Clinical Acumen of the Old Physicians* are alone worth the price of the volume. It would make an excellent gift for a physician of literary inclination.

Harry L. Arnold, Jr., M.D.

Hypothyroidism.

By Paul Starr, M.D., 127 pp., Price $3.75, Charles C. Thomas, 1954.

This is an interesting small monograph which is easily and quickly read. After reading this, I am sure that all of us are missing many cases of hypothyroidism. Dr. Starr stresses the value of protein bound iodine determinations in the diagnosis of this condition and other disorders of the thyroid gland. The BMR is entirely unreliable and the machines should all be thrown in the rubbish pile. As yet the PBI test is complicated and expensive, but perhaps new ways will be devised to simplify it. Dr. Starr shows that probably we err in giving too small doses of thyroid in many instances. He also stresses an old clinical maxim; namely, the more severe the hypothyroidism the smaller the initial dose of thyroid.

J. L. Bell, M.D.

Laboratory Aids in Endocrine Diagnosis.

By Roberto F. Escamilla, M.D., 131 pp., illustrated, Price $4.75, Charles C. Thomas, 1954.

This compendium by an Associate Clinical Professor of Medicine from the University of California is a well organized, well written, and easily understood summary of laboratory (including x-ray) aids in diagnosing endocrine abnormalities. The final chapter is a disease index wherein the appropriate laboratory findings are listed under each abnormality. This provides for a cross reference since the main body of the work is concerned with abnormalities indicated by various tests. Like all compendia, this book's very purpose is one of its drawbacks: for although as Justice Cardozo said, "There is an accuracy that defeats itself by over emphasis of detail," nevertheless it is likewise true that an oversimplification tends also to detract from truth. Therefore the readers must realize this is a general guide and under no circumstances a final authority on the subject. It is rather a quick handy reference for those who deal with endocrine problems occasionally.

Physically the volume is small and well bound with large legible print and excellent although few illustrations, both black and white and in color.

W. Harold Civin, M.D.

Also Received

The Medical Clinics of North America.

July 1954, Mayo Clinic Number—Bronchial and Pulmonary Disease, pp. 943-1253, figs. 88-161.

Thirty-four articles in a symposium on bronchial and pulmonary diseases.

September 1954, Boston Number—Specific Methods of Treatment, pp. 1255-1560, figs. 162-169.

An excellent issue of Boston with particularly good articles on allergy, mycoses, neurotic patients, and dysmenorrhea.

November 1954, Philadelphia Number—Cardiovascular Diseases, pp. 1561-1856, figs. 170-193, $18 per clinic year, cloth binding; $15 per clinic year, paper binding, W. B. Saunders Company, 1954.

Eighteen articles in a symposium on cardiovascular diseases.

The Surgical Clinics of North America.

April 1954, New York Number—New Techniques in Surgery, pp. 291-585, figs. 170-193.

Twenty articles in a symposium on new techniques in surgery.

(Continued on Page 260)

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BOOK REVIEWS

(Continued from Page 258)

October 1954, Pacific Coast Number—Total Care of the Surgical Patient, pp. 1199-1491, figs. 300-334, $18 per clinic year, cloth binding; $15 per clinic year, paper binding, W. B. Saunders Company, 1954.

Pacific Coast Surgical Association put this issue together.

The Clinical Significance of Disturbances in the Delivery of Sweat.

By Marion B. Sulzberger, M.D., and Franz Herrmann, M.D., 212 pp., illustrated, Price $6.75, Charles C. Thomas, 1954.

An authoritative analysis on what can go wrong with the sweat gland.

The Pyramidal Tract.

By Arthur M. Lassek, Ph.D., M.D., 166 pp., Price $4.75, Charles C. Thomas, 1954.

This tells more about the pyramidal tract than most doctors want to know. A valuable reference for the neurologist.

Atlas of Distribution of Disease.

Explored Areas of Arthropod-Borne Viral Infections (Yellow Fever and Dengue Excepted), Price $1.25 folded, $1.50 flat, American Geographical Society, 1954.

Another in the series of beautiful and authoritative contributions to geographical medicine.

The Graphomotor Projection Technique.

By Samuel B. Kutash, Ph.D., and Raymond H. Gehl, M.D., 133 pp., Price $3.75, Charles C. Thomas, 1954.

"Doodling" made psychiatrically instructive. Fascinating!

The Work of WHO 1953.

Official Records of the World Health Organization No. 51, 190 pp., Price $1.50, Columbia University Press, 1954.

A valuable and impressive documentation of the World Health Organization's activities.

Donovanosis.

World Health Organization: Monograph Series No. 24, By R. V. Rajam, M.S., F.R.C.P., and P. N. Rangiah, M.D., 72 pp., illustrated, Price $1.50, Columbia University Press, 1954.

World Health Organization Technical Report Series No. 77—Expert Committee on Environmental Sanitation; No. 78—Expert Committee on Rheumatic Diseases; No. 82—Expert Committee on Rabies; No. 83—Methodology of Planning an Integrated Health Programme for Rural Areas, Price $.25 each, Columbia University Press, 1954.

Myocardial Infarction.

By Irving S. Wright, M.D., Charles D. Marple, M.D., and Dorothy Fahs Beck, Ph.D., 656 pp., Price $8.50, Grune & Stratton, Inc., 1954.

An official report of the Committee on Anticoagulants of the American Heart Association. There are 91 appendix tables and 192 graphs.

Modern Diagnosis and Treatment of the Minor Venereal Diseases.

By Orlando Canizares, M.D., 131 pp., illustrated, Price $3.75, Charles C. Thomas, 1954.

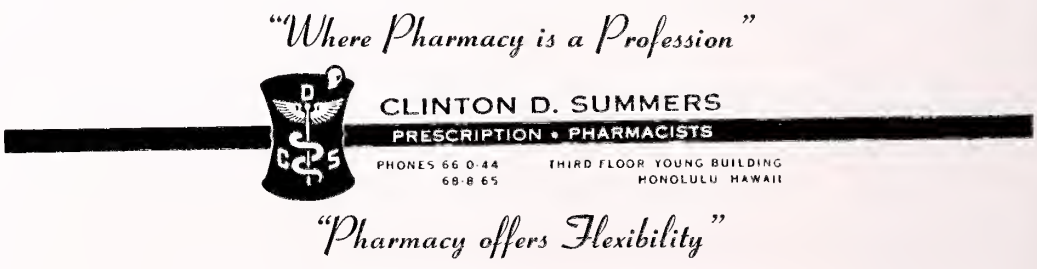
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By Cecil K. Drinker, M.D., illustrated, Price $5.50, Charles C. Thomas, 1954.

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**Heck, W.E.; Lynch, W.J., and Graves, H.L.: Acta oto-laryng. 43:416, 1953.*

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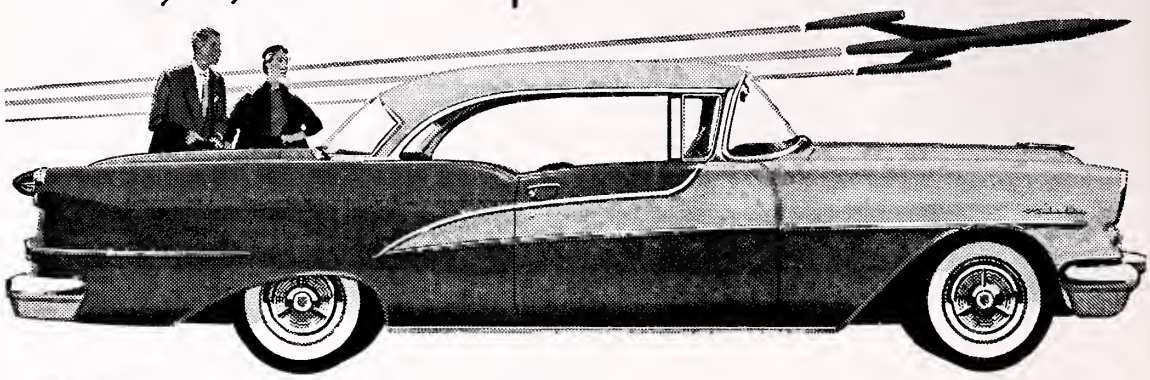


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ELECTRON PHOTOMICROGRAPH

Streptococcus faecalis 40,000 X

Streptococcus faecalis is a Gram-positive organism commonly involved in a variety of pathologic conditions, including urinary tract infections • subacute bacterial endocarditis • peritonitis.

It is another of the more than 30 organisms susceptible to

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3 GLASSES OF FRESH MILK A DAY

can do this much for your patients!

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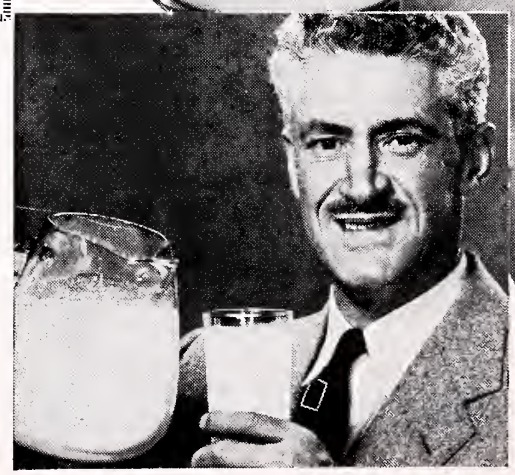
2 EASES NERVOUS TENSION. Tests of a number of nervous children and adults prove that drinking three glasses of milk every day helps reduce fatigue and strain. Milk is so good, so refreshing—and, unlike other beverages, it contains no drugs that may increase nervousness.

3 ENDS CALCIUM STARVATION. More Americans suffer from calcium deficiency than from any other dietary lack. We all need calcium all our lives for teeth, bones, and proper body functioning. Milk is the only practical source of calcium. Three or four glasses every day provide the daily calcium requirement for a normal adult.

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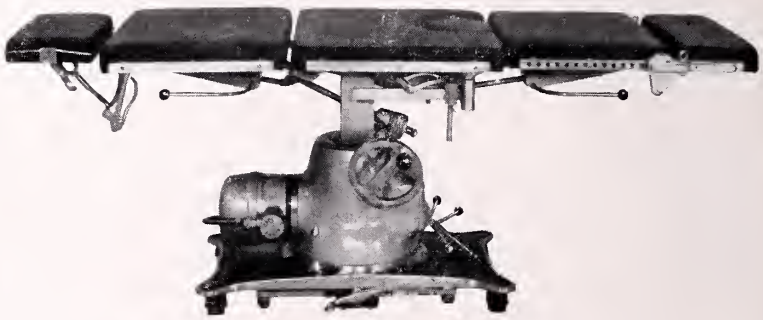
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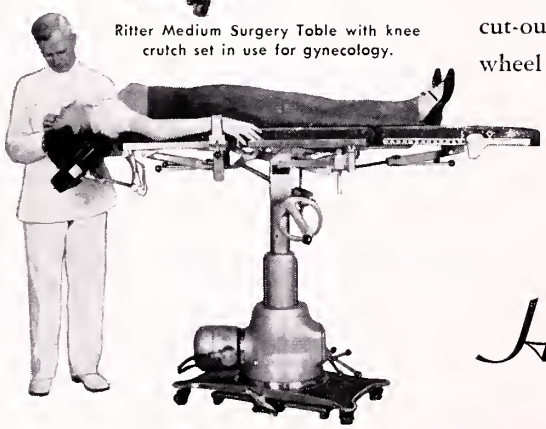


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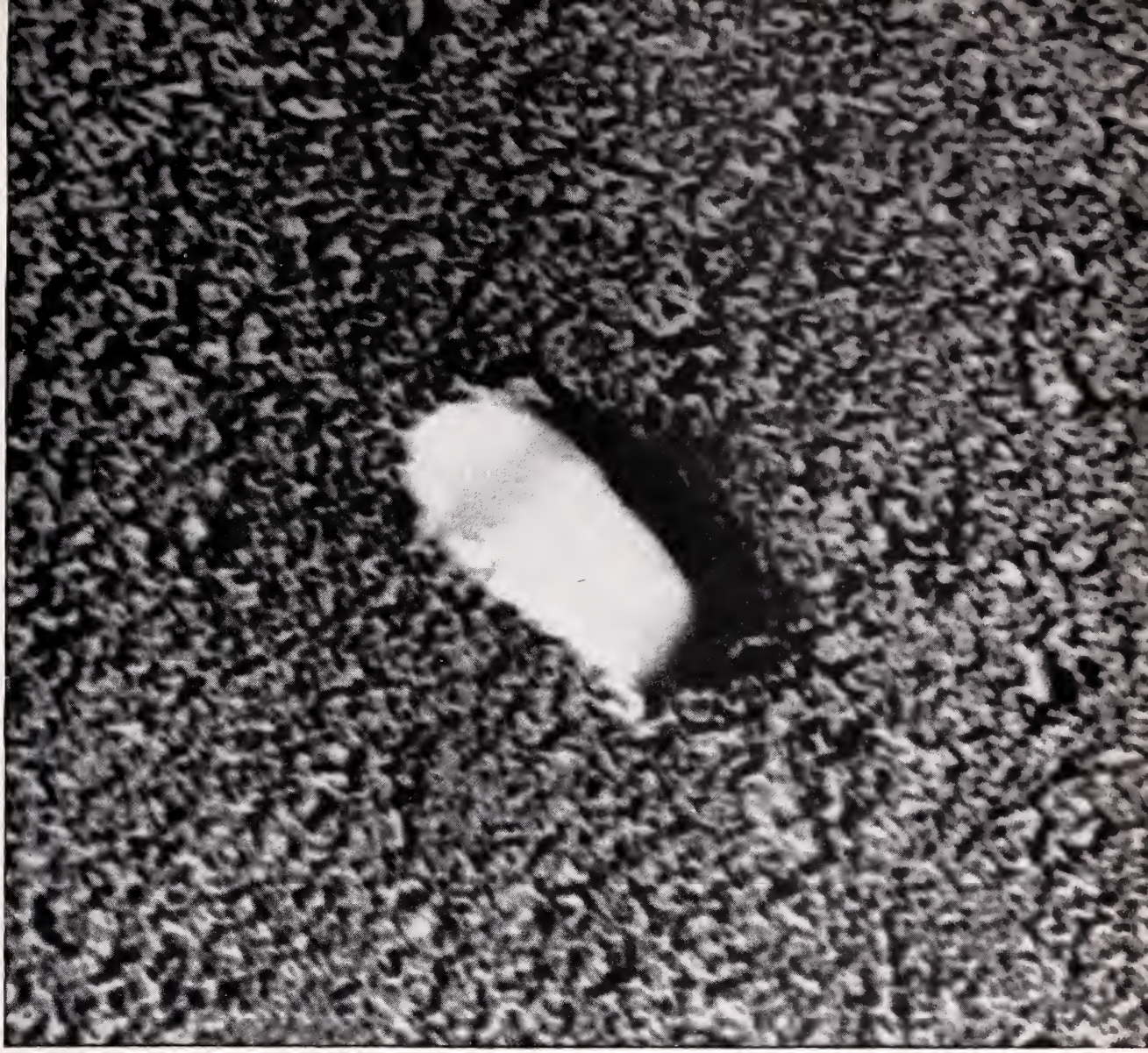
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Klebsiella pneumoniae 39,000 X

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It is another of the more than 30 organisms susceptible to

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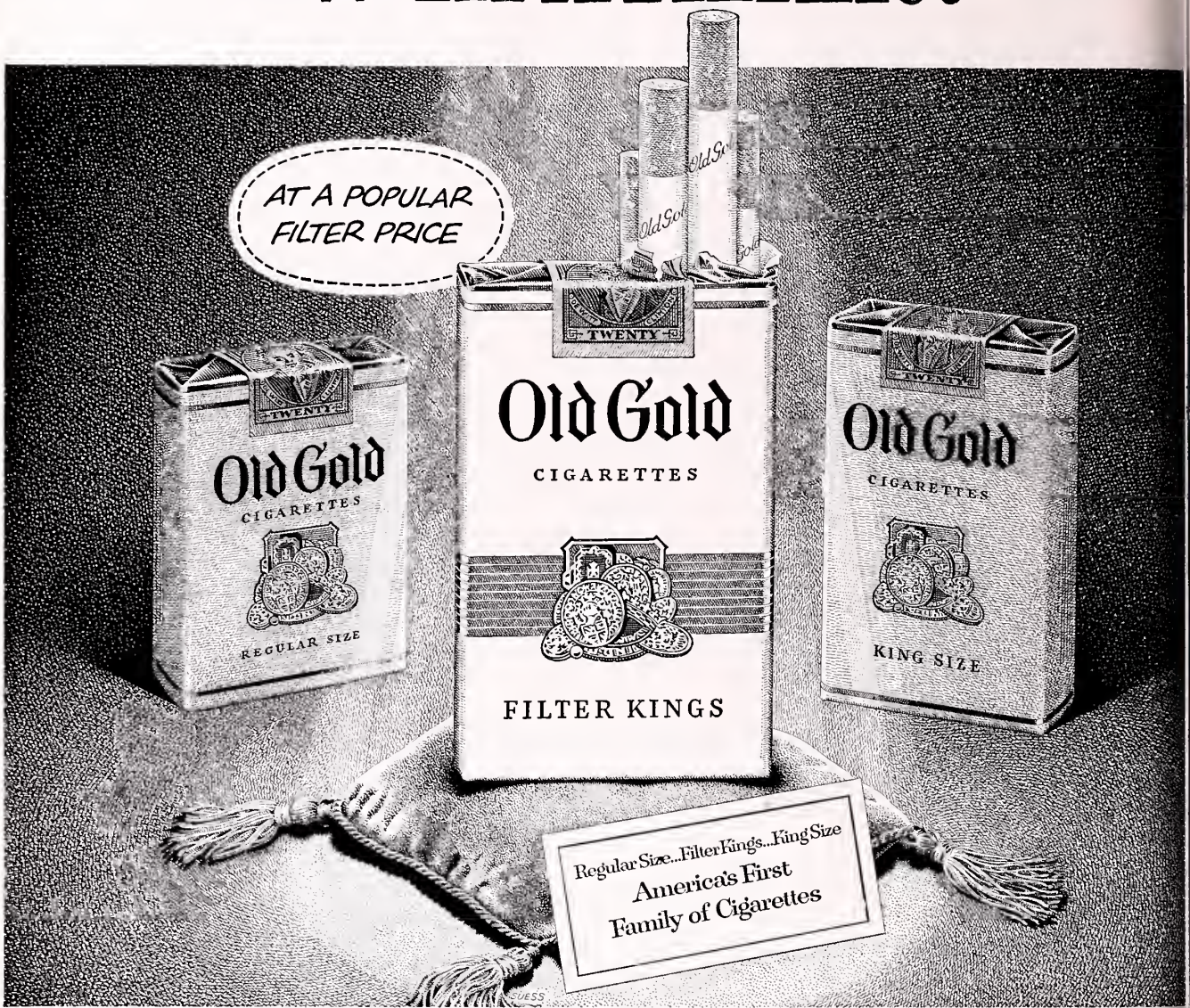
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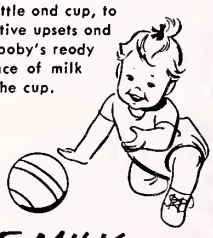
Cattle from the world-champion Carnation bloodlines are shipped to Carnation supplier herds throughout America.

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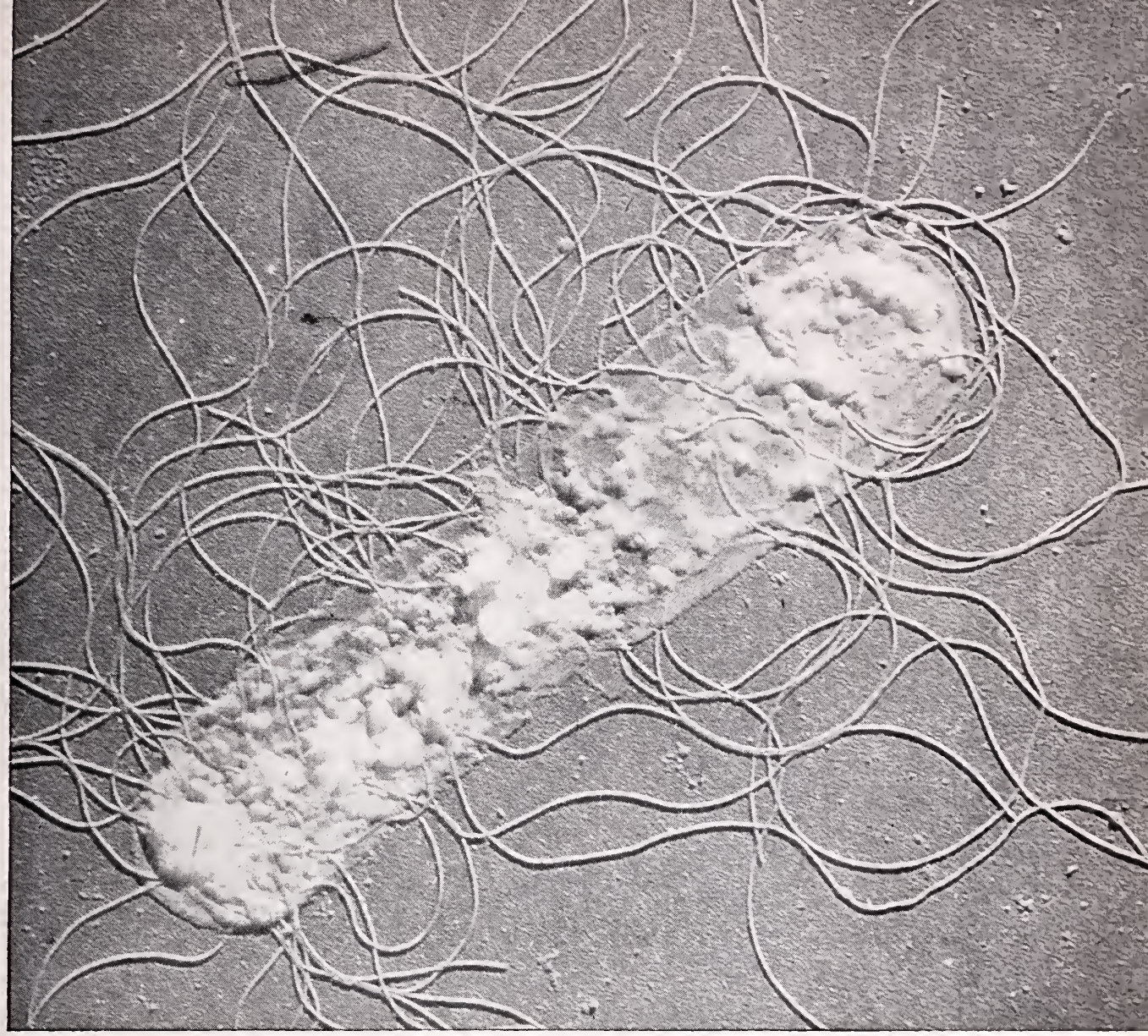
(3) In the Carnation Laboratories, continuing research guards the purity and the nutritive values of Carnation Milk—develops new and improved processing methods.



(4) Every drop of Carnation Milk is processed solely by Carnation, in Carnation's own plants, to Carnation's high standards, assuring constant high quality, uniformity.



(5) Carnation store stocks are date coded and inspected regularly by Carnation salesmen to assure freshness and high quality whenever a mother makes her purchase.



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urinary tract infections • septicemia

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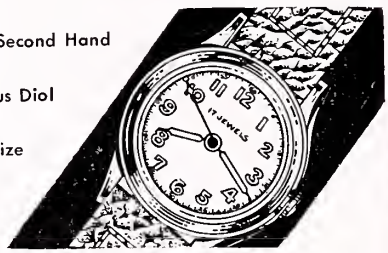
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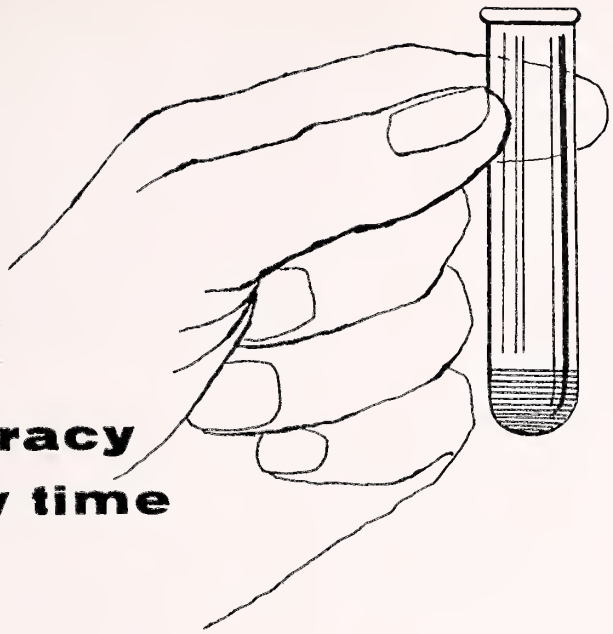
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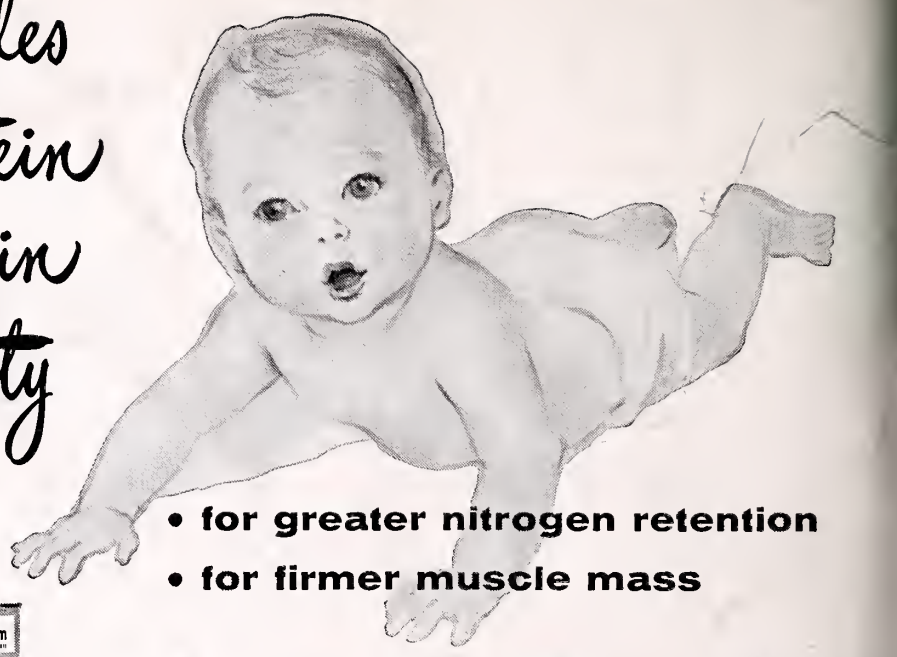
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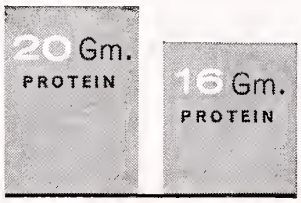


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Recommended Daily Allowance for a 10 lb. infant

1. Jeans, P. C., in A.M.A. Handbook of Nutrition, Philadelphia, Blakiston, 1951, pp. 275-298. 2. Stare, F. J., and Davidson, C. S., in The Proteins, American Medical Association, 1945.

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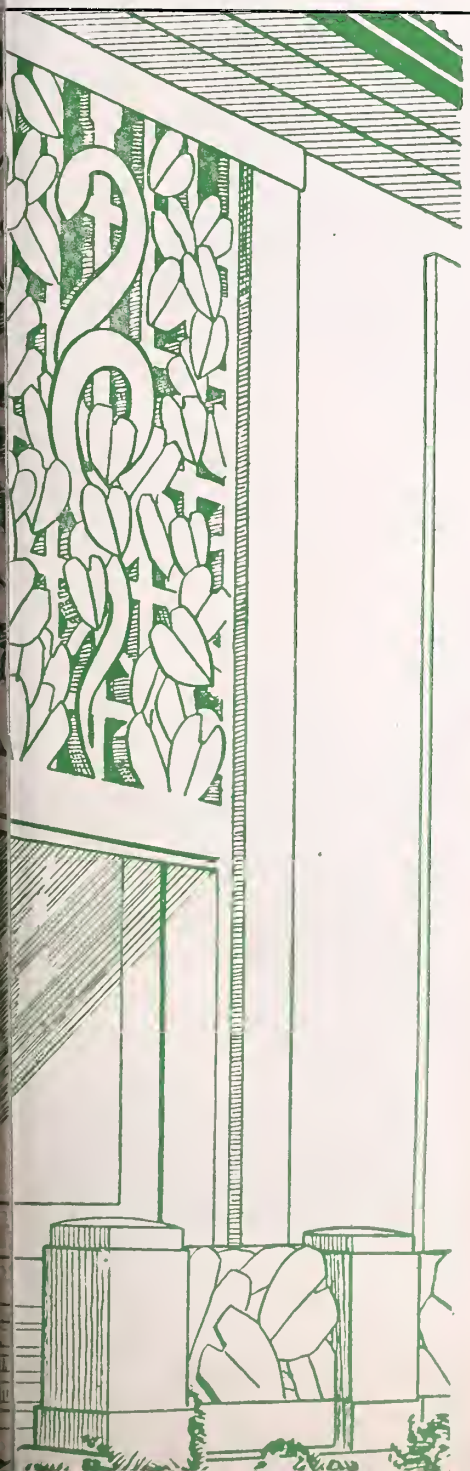
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and

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THE N.Y. ACADEMY OF MEDICINE
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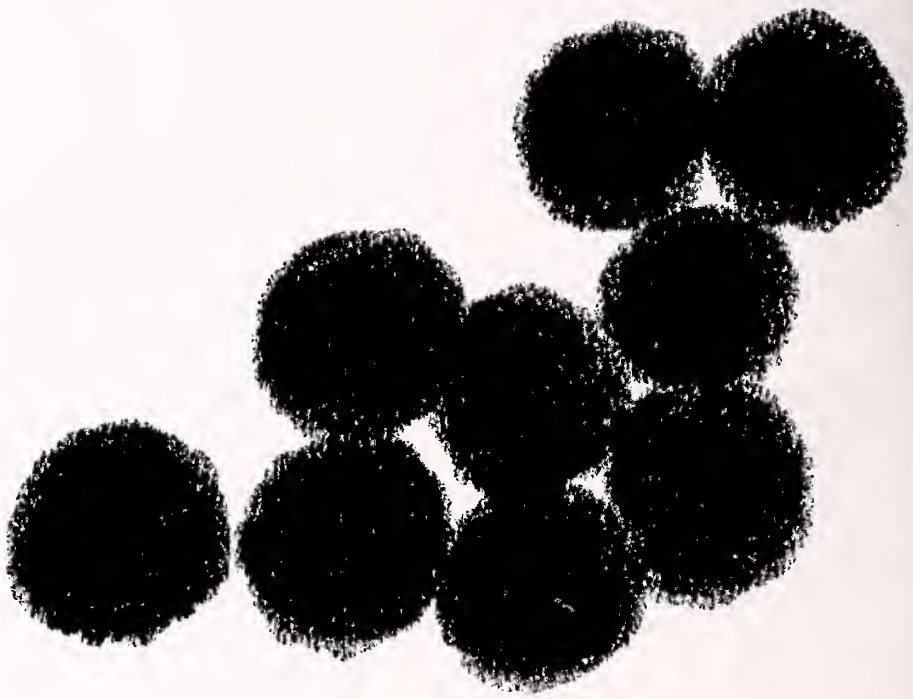
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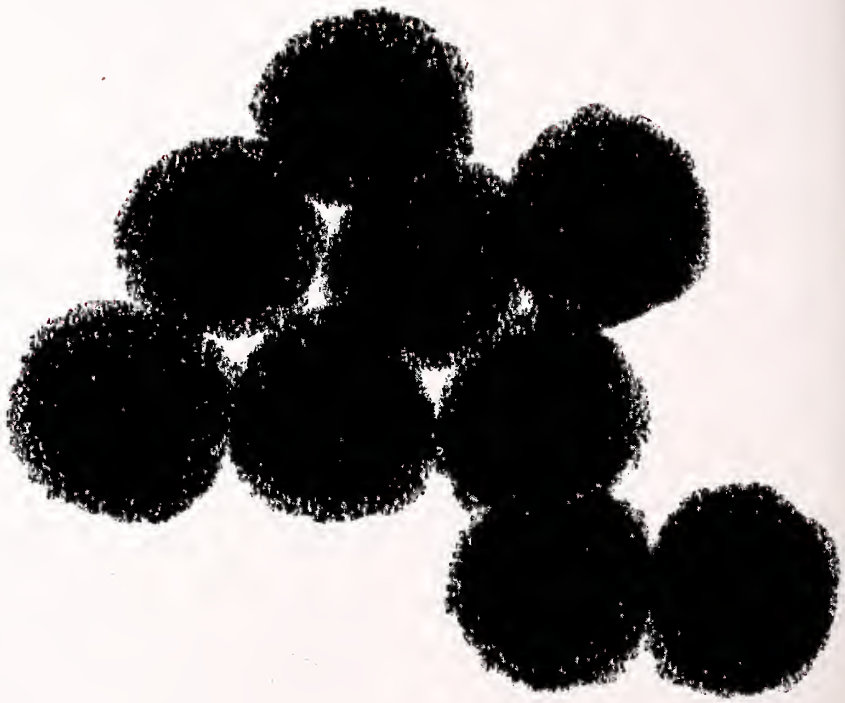
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*Pratt, R., & Dufrenoy, J.: Texas Rep. Biol. & Med. *12*:145, 1954.

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INTER-ISLAND NURSES' BULLETIN

Volume 14
Number 4

MARCH-APRIL, 1955

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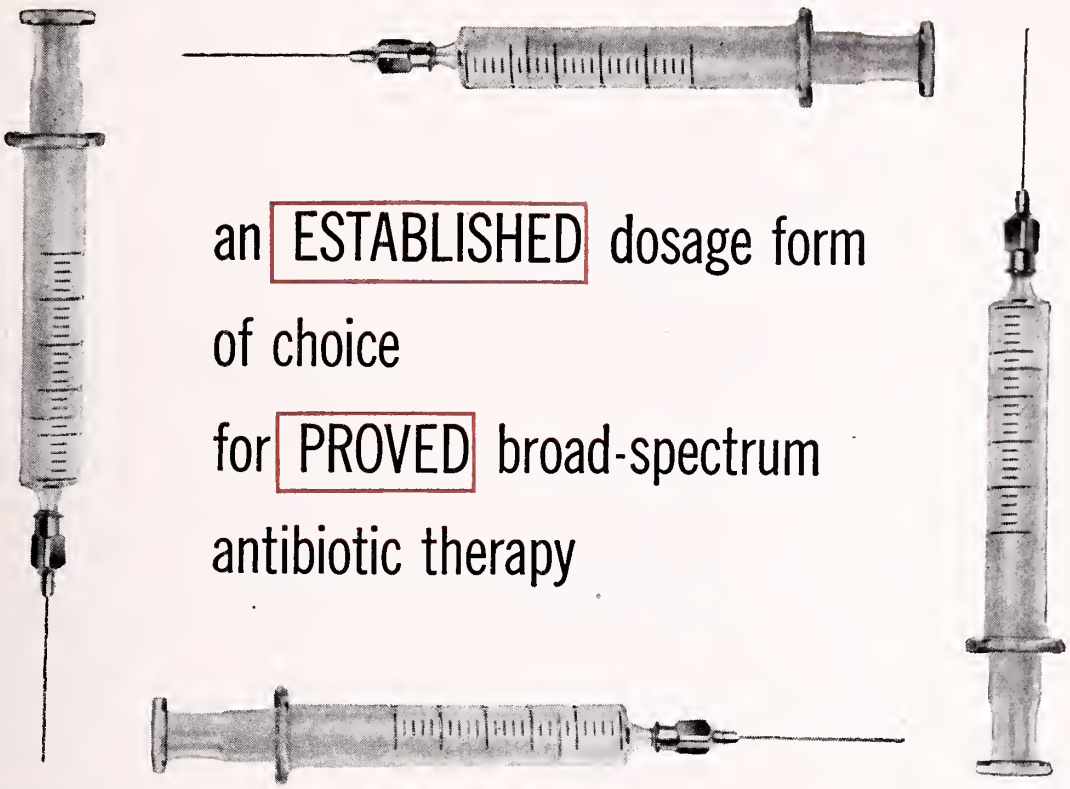
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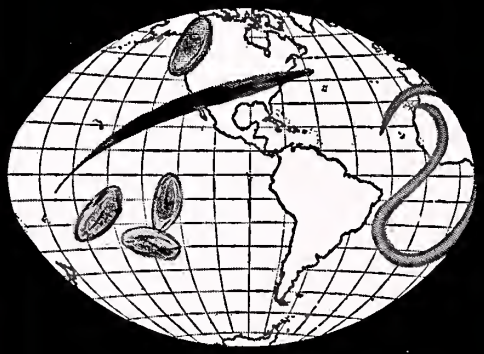
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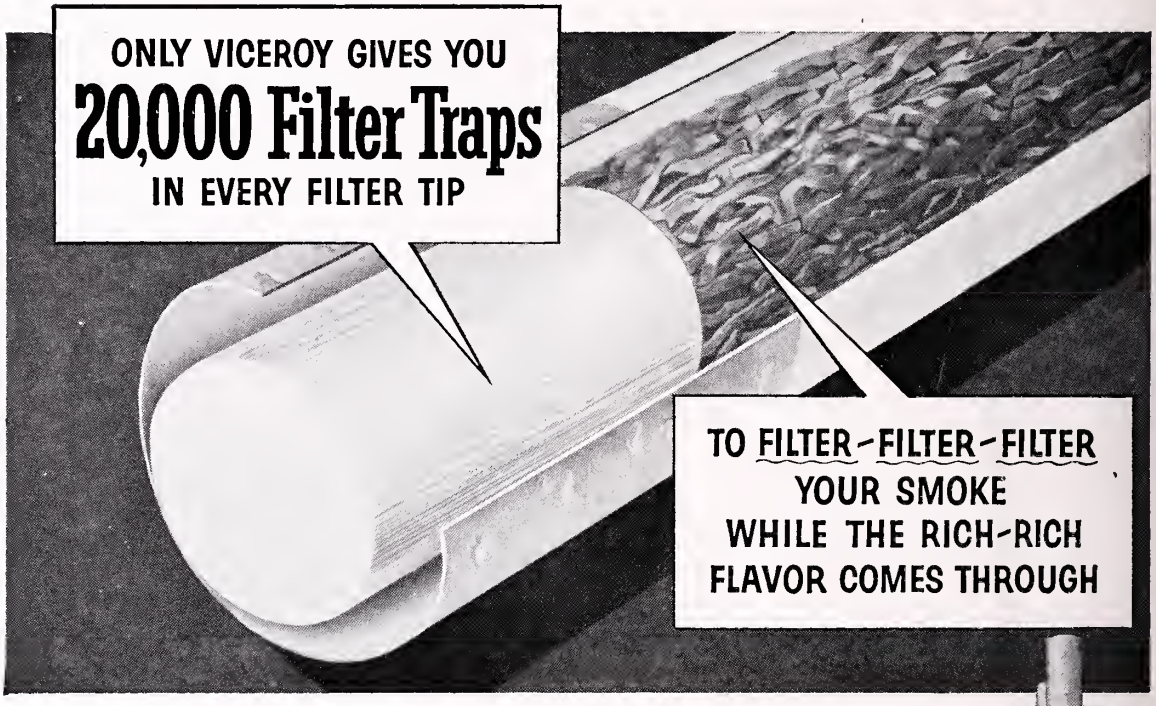
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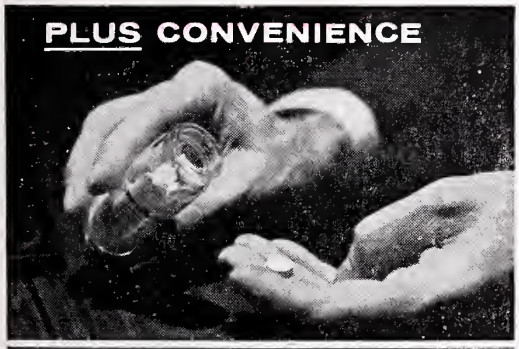
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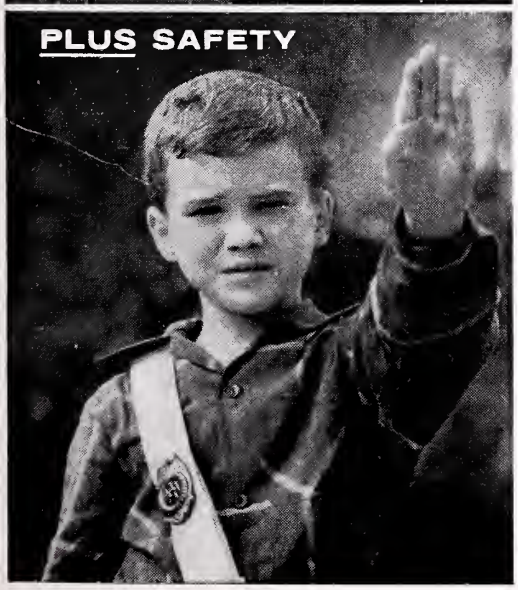
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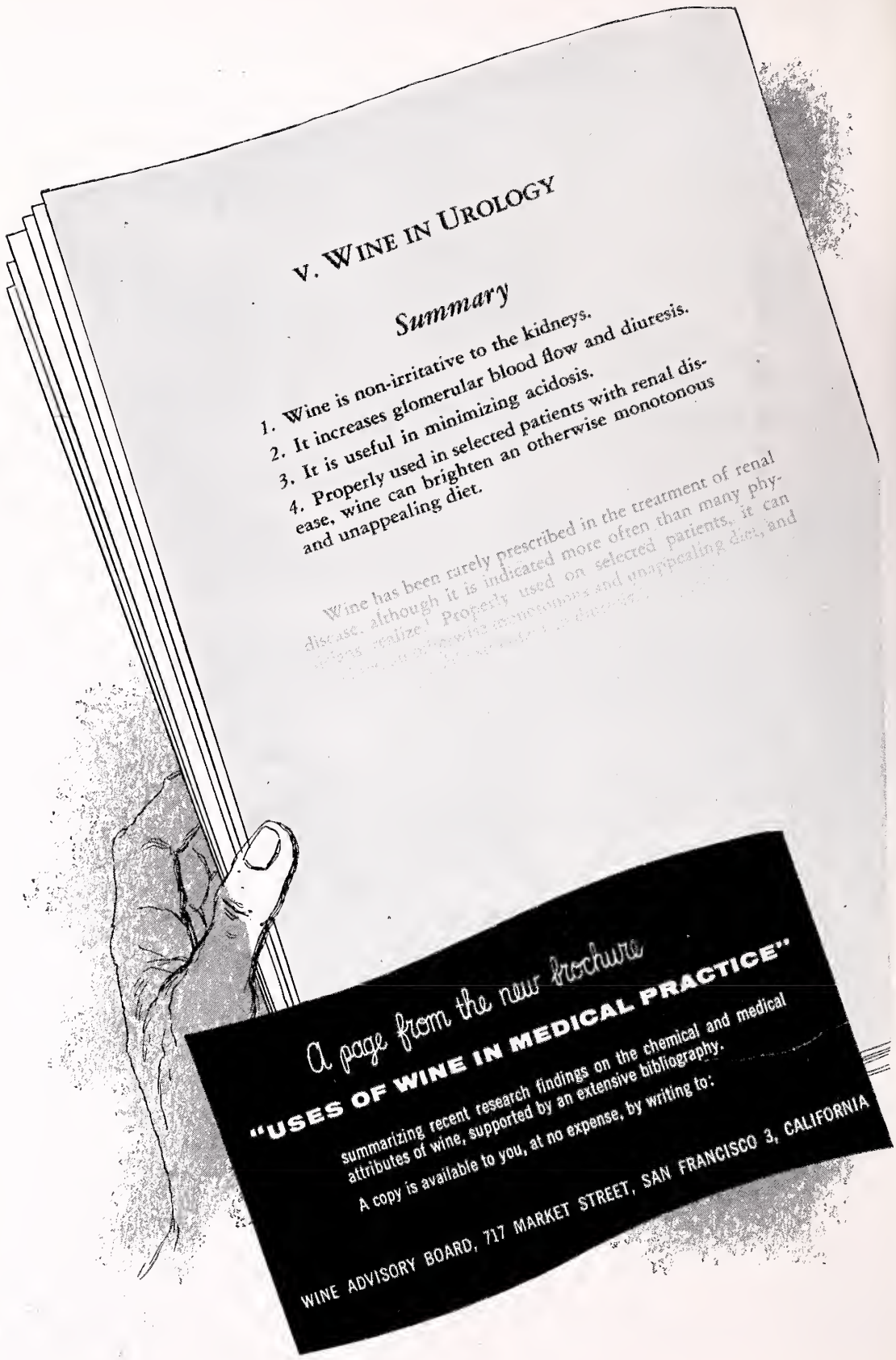
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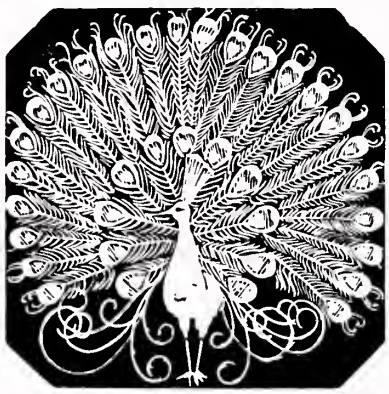
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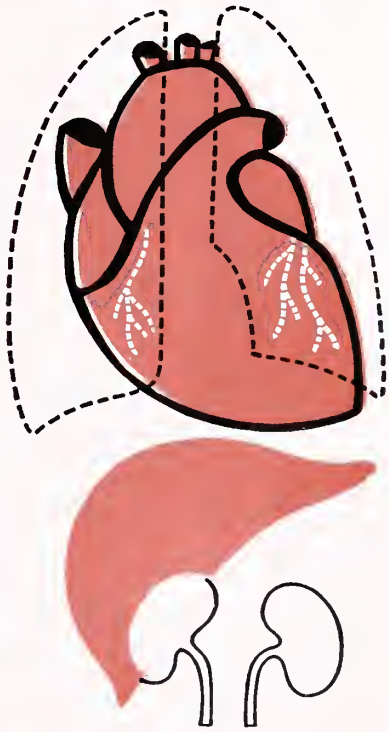
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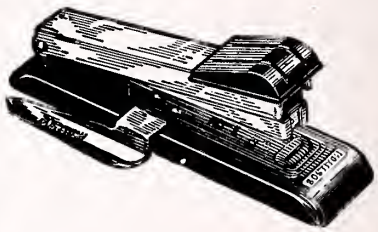
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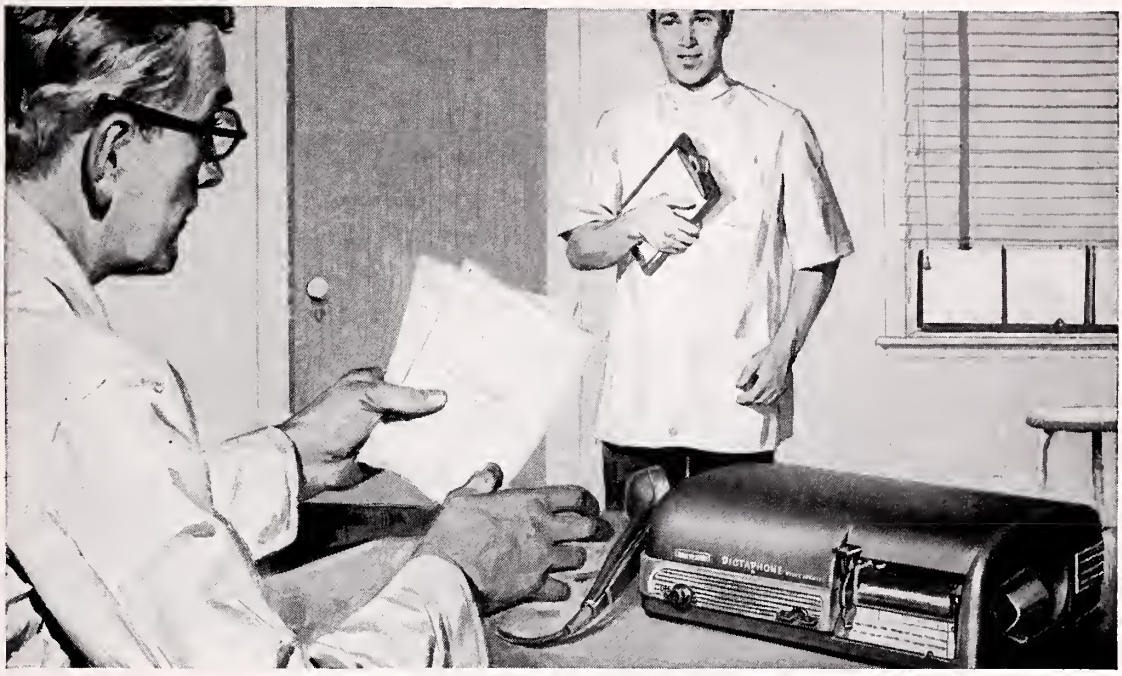


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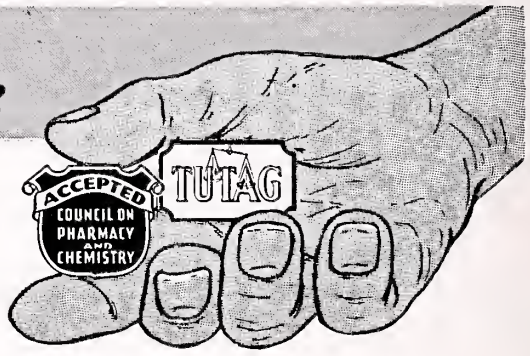
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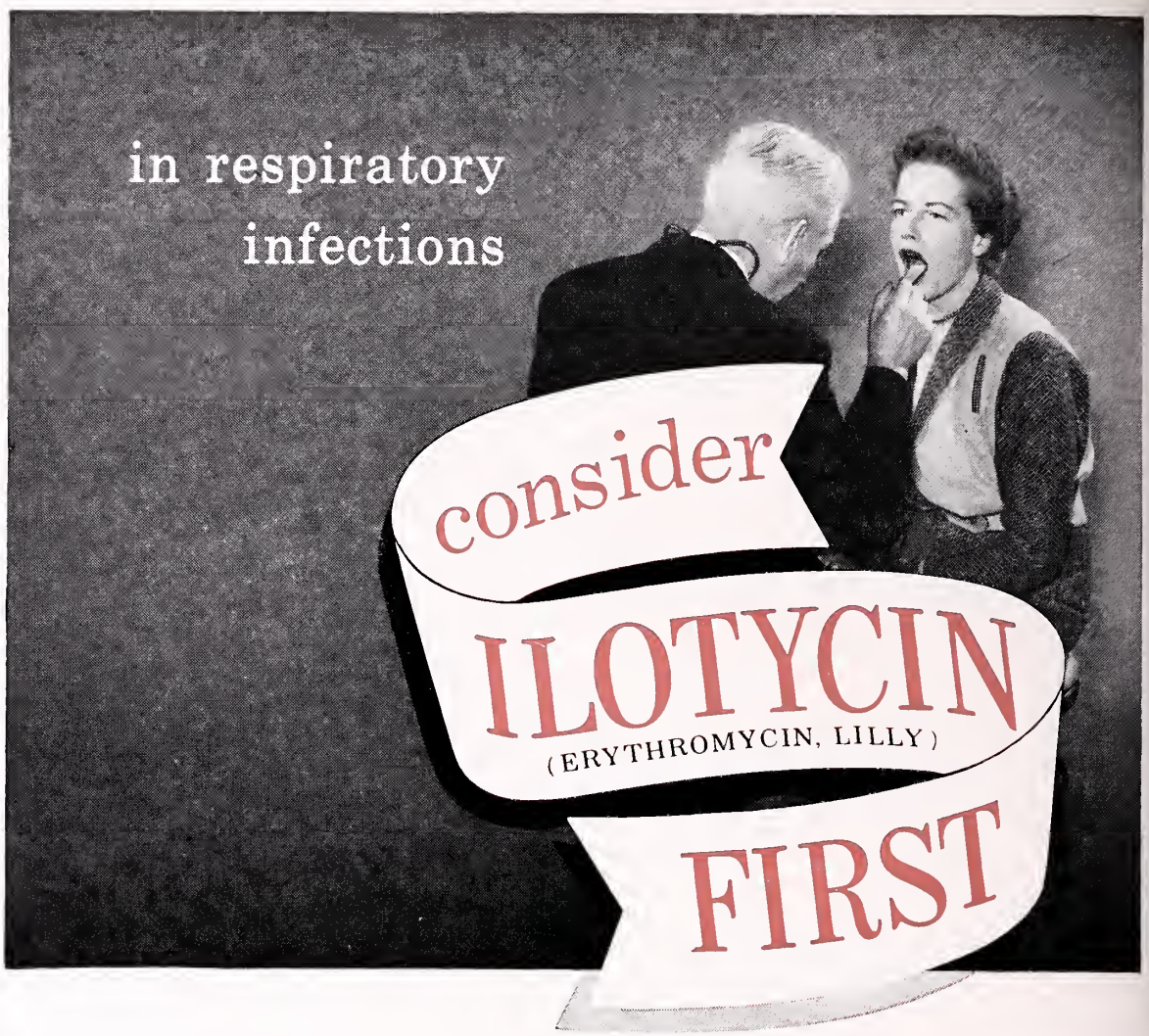
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FACTORS AFFECTING THE BIOLOGICAL BEHAVIOR OF GASTRIC CARCINOMA

With Special Emphasis on Survival Rates

IAN MACDONALD, M.D., and PAUL KOTIN, M.D.,* Los Angeles

IN the course of reviewing 1,467 cases of gastric carcinoma at the Los Angeles County Hospital and 556 cases from private associated institutions, it became increasingly apparent that gastric carcinoma presents a biological behavior pattern which makes survival rates relatively independent of duration of symptoms, gross and histopathologic pattern, and the degree of radicalism of surgery. The clinical and diagnostic factors of age, sex, and pre-existing gastric pathology also proved to be of little value in estimating the prognosis as measured by survival time for patients with gastric carcinoma.



DR. MACDONALD

The biological spectrum of behavior of gastric carcinoma encompasses neoplasms in which the growth potential is limited, symptom duration is prolonged, and dissemination tendencies are feeble, at one extreme, and, at the other, lesions in which growth capacities are high, and their clinical reflections are manifested by short symptom intervals and by early aggressive local and metastatic spread.

The former group comprises those patients in whom improvement in survival rates has the greatest likelihood of success. The latter group frequently presents little or no symptomatology, so that a high percentage of such cases die with the primary lesion undiagnosed, and in the remainder a state of incurability, developing simultaneously with the onset of the earliest symptom, is the rule. It is of especial interest to note that in one-third of the patients with gastric carcinoma, the first symptoms are related to the metastases rather than to the primary growth. Preliminary observations would indicate that the present emphasis on early diagnosis, predicted on clinical symptoms, not only offers little hope to the way of improving survival rates, but rather is an admission of the futility of early diagnosis. The actual clinical sequence observed is that the more severe and rapidly developing the symptoms are, the earlier the diagnosis is made, and the sooner death ensues. Following is an analysis of the several factors concerned with the clinical diagnosis of gastric cancer, which lead to this inescapable conclusion.

The interval between symptom onset and the start of definitive therapy shows a consistent tendency to correlate the better prognoses with the greater lengths of history. This paradox becomes resolved when the biological behavior of gastric cancer is analyzed and the results of ever-increasing heroism in surgery are reviewed. Early diagnosis does, indeed, increase resectability rates, particularly with the super-radicalism currently employed by some surgeons. Unfortunately a betterment of end results, and an increase in survival rates, fail to parallel this expanding ability to treat the neoplasm by the surgical method. The gross pathologic characteristics of the neoplasm as detected clinically (notably palpability of tumor mass, obstruction, and poor nutritional status) may indicate a favorable biologic situation. In effect, we have a number of phenomena, all of which traditionally would indicate a uniformly bad prognosis, characteristic of patients in whom survival rates are greater. The reciprocal relationship, seen in patients with the obverse clinical-pathologic characteristics, serves only to emphasize the validity of this basic conclusion.

The many and multiplying reports on the ever-increasing rates of operability and resectability authoritatively document this trend. Equally apparent, however, is the fact that not only have survival rates failed to keep pace with this growing surgical success, but analyses actually indicate a relative and disproportionate *decrease* in "cures." The gap between resectability and survival rates is an ever-expanding one. The increasingly radical nature of surgery, associated with and subsequent to the improved pre- and post-operative care of the patient, has thus far failed to indicate that even at some future date will significantly increased survival rates result from this approach. A biologically exuberant neoplasm very rapidly reduces, perhaps to the point of non-existence, the chance of therapeutic success.

Observations at the time of surgery also substantiate the inexorable course of some gastric

* From the Departments of Surgery and Pathology, School of Medicine, University of Southern California.
Received for publication on October 15, 1954.

cancers, and the indolent course of others. The intramural extension both laterally and transmurally, the pattern of lymphatic spread, and the panorama of distant metastases all combine to suggest that from both a technical and a biologic viewpoint gastric cancer is at present a surgically insoluble problem. Assuming that all such patients were subjected to total gastrectomy with splenectomy and pancreaticoduodenectomy, the exceedingly frequent demonstration of metastases in the additionally included resectable nodes, and in the adjacent partially resectable lymph nodes for biopsy only, would emphasize the futility of this super-radicalism. The successful demonstration of lymph node involvement in ever-expanding surgically resectable areas in and of itself demonstrates the need for going one step farther. The limits of surgically resectable margins would seem at this time to have already been reached.

An assessment of the gross pathologic features of gastric cancers would indicate that their macroscopic typing or grouping is the only factor which shows a relatively significant prognostic association. The association is most evident in Type I or polypoid carcinoma and Type IV or diffuse infiltrating carcinoma, with the two intervening Borrmann types showing less consistent prognostic indices. Location and size of tumor are of limited value insofar as relating them to survival rates is concerned.

Microscopic features are correlatable with survival rates only to a limited degree. Since essentially all gastric tumors are mucous cell in origin, the actual histopathologic pattern of growth observed is more a reflection of pathological change than a true picture of overall tumor pattern. The scarcity of neoplasms with uniform microscopic features precludes any attempt to successfully correlate a single cell or histologic pattern with prognosis. In my limited experience, exclusive glandular patterns are so rare as to be virtually non-existent.

Despite the extraordinary diversity in growth pattern exhibited by gastric carcinoma, our analysis indicated that highly differentiated adenocarcinoma and the special undifferentiated carcinoma of Steiner formed the largest histologic group associated with the prolonged survival rates, whereas the mucinous carcinoma, infiltrating scirrhous carcinoma, and undifferentiated anaplastic carcinoma showed their highest percentage in the group with the lowest survival rate.

Of unquestionably greater significance than the cell type or glandular pattern is the degree of intramural spread and circumscription of tumor borders within the stomach wall. Intramural extension of the florid type is usually ominous, and cancerization of the mucosa beyond the limits of visibility or palpability is almost invariable in the non-circumscribed group. Maintenance of a theoretical line of delineation, between the advancing tumor and the normal gastric mucosa, apparently represents the sole relatively successful, microscopically demonstrable attempt, on the part of the host, to resist the neoplasm.

Transmural extension and lymphatic spread present no data correlatable with prolonged survival rates except in a completely dismal light. This pattern of extension with serosal involvement and subsequent lymphatic spread does, however, point up one cardinal therapeutic axiom. Cure, when not attainable by genuine subtotal gastrectomy with wide omental resection and splenectomy, is in all likelihood unattainable regardless of the degree of surgical heroism undertaken. Studies on nodal metastases indicate that extension beyond the perigastric nodes and the pancreaticolienal nodes requires a degree of radicalism in surgery that is of itself tantamount to an admission of therapeutic failure. As a rule, involvement of such secondary node areas as hepatic and subpyloric groups indicates further extension to the celiac axis group of periaortic nodes and involvement of the surrounding viscera. A true radical lymphadenectomy without the total extirpation of the adjoining viscera would appear to be impossible. Even if this theoretically desirable procedure were practical, its implementation serves to further emphasize the need for even greater radicalism.

An analysis of necropsy data further verifies these observations concerning growth potential and prognosis. In patients without previous gastrectomy, from eighteen to twenty-eight per cent have local lesion growth so limited and metastatic spread so restricted that at the time of death their lesions were in a theoretically operable state. This equals a pattern of indolence. In post-resection cases, it has also been noted that local growth and regional spread of gastric carcinoma conform to the outlined biologic pattern of exuberance. Failure of local control has been almost universally lamented by those reviewing the autopsy findings in this group, though they fail to prove that gastric or duodenal recurrence was not accompanied by either distant metastases or by regional spread, usually beyond technical operability. The fact that eighty per cent or more of post-resection autopsies show failure of local control can most logically be explained as evidence that this major fraction is biologically uncontrollable, leaving about twenty per cent in which the local disease may be surgically encompassed.

(*Continued on page 356*)

RECENT TRENDS IN THE MANAGEMENT OF HEAD AND NECK MALIGNANCIES

GROVER H. BATTEN, M.D., Honolulu

RECENT years have witnessed the expansion of the surgical attack upon malignant disease. Present trends in the management of head and neck cancer are a spectacular example. Because of improved anesthesia, more adequate blood replacement, the introduction of antibiotics, and better methods of reconstruction, the previously high morbidity and mortality have been reduced and this type of surgery is now safe. That it is also worthwhile is shown by the number of patients who have been followed long enough to emphasize that extended surgery has a great deal to offer in both salvage and palliation. Accordingly, the attitude of pessimism—indeed, nihilism—held by the medical profession in the past, is no longer justifiable, making aggressive management mandatory.



DR. BATTEN

Lymphatics

The majority of head and neck cancers confine their metastatic deposits to the lymphatic bed in the neck. It is important, therefore, to consider the cervical lymphatics, for if we are going to cure these people, we must control not only the primary disease but this area as well.

The internal jugular chain (Fig. 1) is the major axis of drainage and, as implied by its name, it runs along the internal jugular vein commencing at the base of the skull and ending behind the clavicle where it empties into the great venous system. The periauricular, submaxillary, submental, prelaryngeal, spinal accessory, and transverse cervical chains are removed from this primary avenue of drainage but eventually, in the main, they empty into the internal jugular chain.[1]

Between these various so-called groups of nodes there is a rich network of interlacing anastomoses which force us to consider all the neck lymphatics as a single system rather than a collection of lymph nodes and lymphatic ducts arranged in discrete anatomical subdivisions or compartments. For this reason we feel that in most cases, if a neck dissection is indicated, the entire neck should be cleaned out. This means that all tissue that can be

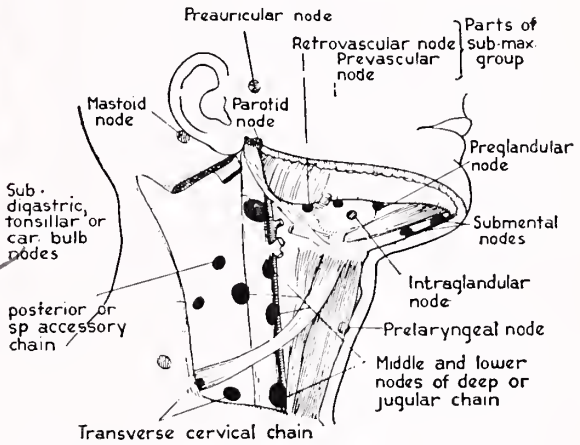


FIG. 1.—The cervical lymphatics drain mouth, pharynx, larynx, major salivary glands, thyroid and parathyroid gland, esophagus, and skin. Complete *en bloc* removal of this system requires resection of the internal jugular vein and sternocleidomastoid muscle.

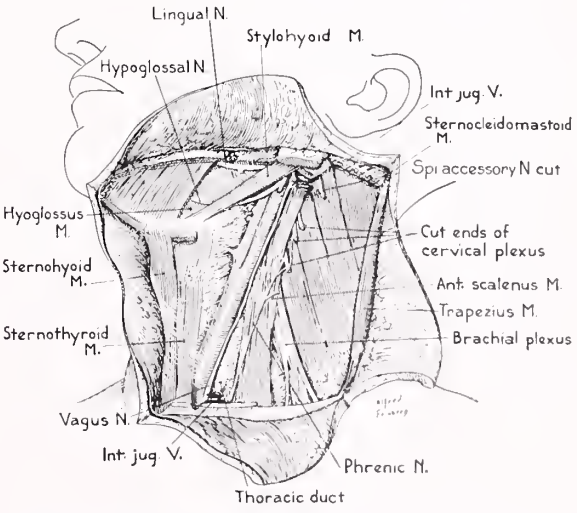


FIG. 2.—Completed standard neck dissection illustrating structures normally preserved. If involved by disease, they must be sacrificed.

Read before the Ninety-eighth Annual Meeting of the Hawaii Medical Association, Honolulu, May 13, 1954.

Figs. 1, 2, 3, 6 and 7 reproduced by permission of Hayes Martin, M.D.

[1] Rouviere, H.: Anatomie Des Lymphatiques De L'Homme, Paris, Masson et Cie, 1932.

sacrificed posterior to the platysma muscle and anterior to the scalene muscles in the area bounded by the midline, the superior margin of the clavicle, the anterior border of the trapezius muscle, and the inferior margin of the mandible, requires removal. To be preserved, whenever possible, are the common and internal carotid arteries (although grafts can be employed where necessary), the vagus nerve, the brachial plexus, the phrenic, hypoglossal, and lingual nerves, the mandibular ramus of the facial nerve, and the cervical sympathetic chain.[2] Figure 2 illustrates the completed operation wherein these structures have been preserved.

This flexible basic operation is the axis about which one ideally approaches head and neck malignancies, for there are a good number of contiguous organ primaries which may be resected in continuity by extending this procedure. These contiguous organs are: major salivary glands, tongue, floor of mouth, gingiva, tonsil, buccal mucosa, palate, esophagus, larynx, pharyngeal wall, thyroid, para-thyroid, and external auditory canal.

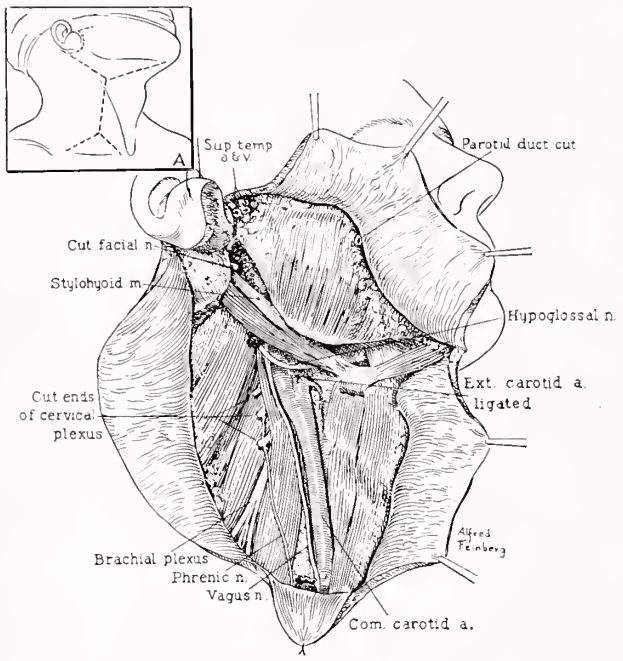


FIG. 3.—Total parotidectomy and neck dissection. The facial nerve need not be sacrificed in all cases.

Parotid

Because of the resistance of parotid cancers to irradiation, these lesions should be resected whenever possible.[3] In all instances where there are obviously involved or highly suspicious neck nodes, total parotidectomy should be extended to include an in-continuity neck dissection as well. This should probably be done with all recurrent parotid malignancies in spite of the absence of obvious nodal involvement. However, there is no unanimity of opinion regarding treatment of the case without evident involvement of the cervical nodes. The safest approach is to recommend a neck dissection in almost every case, the possible exceptions being the known low grade lesions. Whenever the facial nerve or its several branches are involved by disease, they should be sacrificed with impunity.

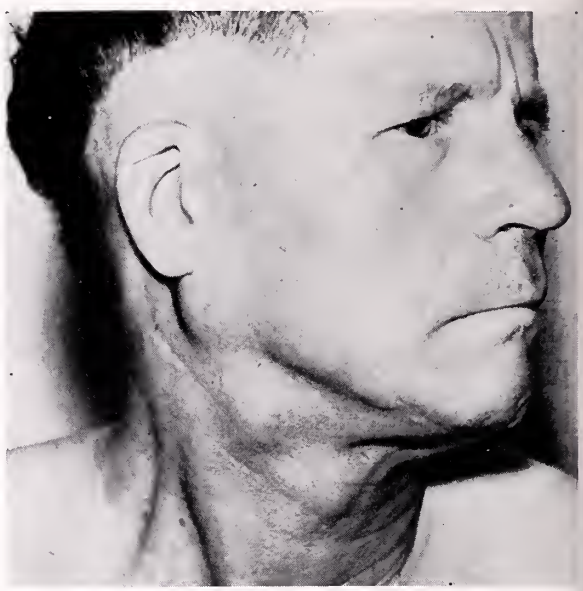


FIG. 4.—Parotid carcinoma with involved lymph node.

In passing, a word should be said regarding benign mixed tumors. In past years, it was common practice for most surgeons to "enucleate" these lesions.[3] The high recurrence rate, approximately 30%, was the result of failure to appreciate the nature of the so-called "capsule" surrounding these tumors. Benign mixed tumors have only an ethereal capsule about them. In addition, they often have numerous pseudopods projecting in all directions. During the removal of the bulk of these tumors, these projections, going unrecognized, were cut across, leading to local recurrences of the "seeding" pattern so frequently encountered. To improve upon results, the operation should be extended to include the removal of a considerable amount of normal gland about the tumor.[4] The most meticulous technique is required if the facial nerve is to be spared, but the recurrence rate of approximately 5% in previously unoperated cases is a sufficient reward for

[2] Martin, H., Del Valle, B., Ehrlich, H., 2nd, Cahan, W. G.: Neck Dissection Cancer 4:441 (May) 1951.

[3] Frazell, E. L.: Clinical Aspects of Tumors of the Major Salivary Glands, Cancer 7:637 (July) 1954.

[4] Martin, H.: The Operative Removal of Tumors of the Parotid Salivary Gland, Surgery 31:670 (May) 1952.

the added time and effort required of the surgeon.[3]

A plea should be made for this procedure not only on the ground that its increased adequacy reduces the number of anticipated recurrences, but also because evidence strongly suggests that a benign mixed tumor may assume malignant characteristics.[5]

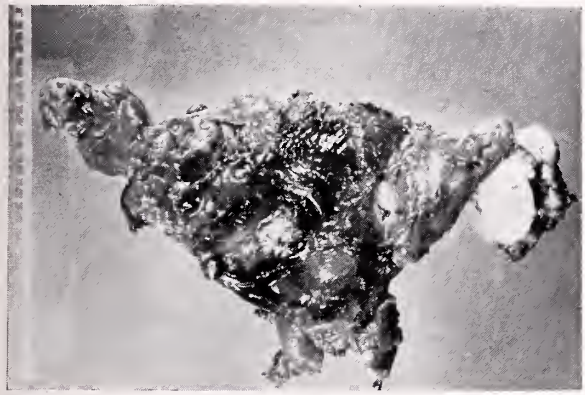


FIG. 5.—Operative specimen which has been partially dissected to demonstrate primary. The involved node is seen (see Fig. 4).

These remarks, directed toward the parotid gland since by far the greatest number of salivary gland tumors occur there, apply in general to the submaxillary and sublingual glands, where similar lesions occur. The only variant is the technical modification required because of their local anatomy.

Intraoral

The removal of a portion of the mandible is not a new operation.[6,7] Nor is the simultaneous employment of some sort of neck dissection. But until recently, the associated morbidity and mortality were so high that the operation was only occasionally attempted. Recent contributions have modified this so that combined operations about the oral cavity are safe.[2]

Lesions arising on or about the lower jaw lend themselves well to combined excision for two reasons: first, they are anatomically adjacent to the upper limits of the standard neck dissection; and second, these lesions frequently metastasize early to the regional lymph nodes.

Over half of all intraoral cancers occur in or around the lower jaw. While some of them may be treated by local excision or some type of excision with marginal resection, most of them require a more extensive removal and frequently the combined operation is required. This may be either because of size, infiltration of bone or adjacent structures, or because they are so located that we know that the lymphatics draining the area are probably running through the periosteum of the mandible.

The question of disability is often raised. Disability depends upon two things: first, the amount of mandible removed; and second, the amount of soft tissue requiring sacrifice.

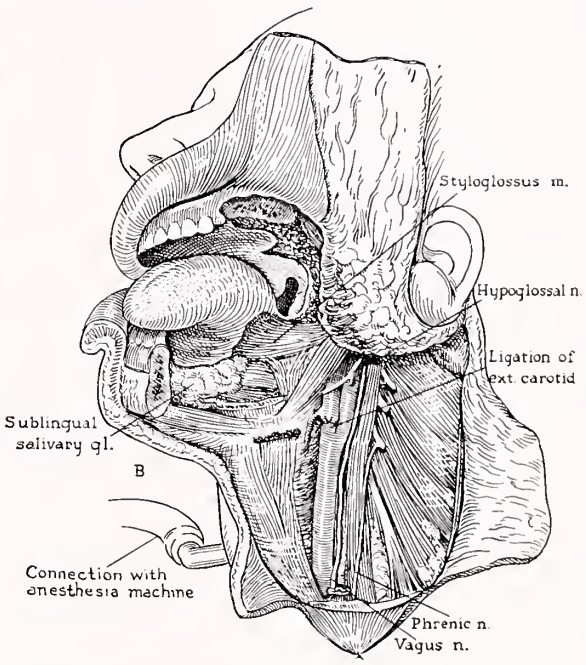


FIG. 6.—Neck dissection extended to include resection of an intraoral primary requiring partial removal of mandible. It is seen that one may include palate, tonsil, lateral pharyngeal wall, tongue, etc.

It is true that this operation may be disabling. But in assessing disability one must be mindful of the natural history of the disease being treated. For example, while a patient may have some limitation of lingual mobility as a result of surgery, it must not be forgotten that the disease treated is progressive and fatal if uncontrolled. Furthermore, radiation therapy carries its own very significant morbidity and salvage limitations. In short, one must be prepared to accept cosmetic and functional alterations philosophically in return for control of disease and relief from inevitable pain and suffering.

Thyroid

Of the several types of thyroid cancers, fortunately the most favorable ones are the most com-

[5] Foote, F. W., Jr., and Frazell, E. L.: Tumors of the Major Salivary Glands, Cancer 6:1065 (Nov.) 1953.

[6] Crile, G. W.: Carcinoma of the Jaws, Tongue, Cheek and Lips: General Principles Involved in Operation and Results Obtained at Cleveland Clinic, Surg., Gynec. & Obst. 36:159 and 177 (Feb.) 1923.

[7] Kocher, T.: Textbook of Operative Surgery. Translation by Harold J. Stiles, London, Adam & Chas. Black, 1903.

mon.[8] Primary treatment of thyroid nodules consists, in general, of removal of the involved lobe and isthmus.[9,10,11,12] If the sections are positive, a neck dissection should be done on the side of the lesion in almost all instances where there is no evidence of nodal involvement. There is no argument, of course, concerning the need for a neck dissection in those cases where there are obviously involved nodes.

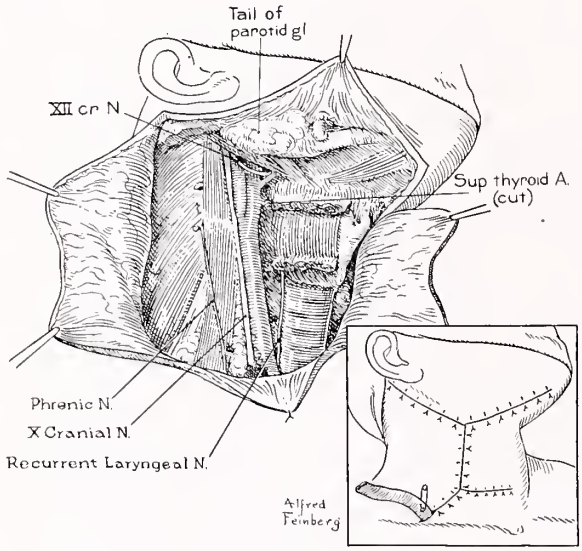


FIG. 7.—Thyroidectomy and in-continuity neck dissection. It is seen how easily even a total thyroidectomy may be done.

It is not difficult to extend the routine thyroidectomy to include an in-continuity neck dissection. Figure 7 indicates the collar incision extension and shows the operative area after resection of thyroid, strap muscles, and neck contents. Whether total thyroidectomy or a lesser operation consisting of removal of the involved lobe and isthmus should be done for thyroid malignancies is unsettled. Because of the possible multicentric origin of many primaries it may be wiser to remove the thyroid *in toto*, although this debatable issue will be solved only by time and careful follow-up.

Concerning so-called low grade or slow growing thyroid cancers, much has been written favoring the individual local excision of palpable nodes only as they become evident, with no attempt being made to clean out the entire node-bearing area.[13] This practice arose because the five-year figures seemed to demonstrate the benignancy of these lesions. The fallacy of this reasoning is beginning to be pointed out by longer term follow-up, which emphasizes that many of these cancers eventually catch up with their hosts.[8,14] The very fact that these tumors are slow in their progression indicates that these people stand the best chance for permanent cure and our efforts should, therefore, be maximum. In short, in most cases the entire neck should be cleaned out, thereby removing all nodes before their microscopic deposits are able to mature and perhaps, metastasize in their turn. In fairness to the opponents of this more aggressive attitude, however, it must be admitted that the question will not be settled for several years.

There is less debate with respect to all-out therapy of the more malignant tumors.

These remarks apply, in general, to papillary, follicular and alveolar, solid, Hurthle-cell, and anaplastic carcinomas. They do not apply to the giant-and-spindle-cell carcinoma which is so lethal —being among the most lethal of all human cancers—that heroic therapy appears to be an unnecessary burden upon both the patient and the surgeon.

Larynx

There are enthusiastic radiologists and surgeons treating early lesions of the intrinsic larynx with reasonable success.[9,12] More extensive disease probably finds more laryngectomists than radiation therapists. And among the surgeons there is disagreement concerning the need to do a neck dissection on those patients presenting themselves for therapy with a rather advanced primary confined to the larynx but without clinically detectable neck metastases. In general, when disease is confined to the larynx, neck dissection should await the appearance of positive disease, because: (1) a large number of patients will never develop metastases to the cervical nodes; (2) if metastases do appear, they may do so in either neck regardless of the side on which the bulk of the primary disease is located; (3) therefore, if one side of the neck is to be done "prophylactically," both sides should be done.

In the presence of metastases or invasion by tumor into the surrounding tissues, there is no question that the contents of one or both sides of

[8] Frazell, E. L., and Foote, F. W., Jr.: The National History of Thyroid Cancer: A Review of 301 Cases, J. Clin. Endocrinol. 9:1029 (Oct.) 1949.

[9] Ackerman, L. D., and Del Regado, J.: Cancer, C. V. Mosby, 1954.

[10] Martin, H. E.: The Surgery of Thyroid Tumors, Cancer 7:1063 (Nov.) 1954.

[11] Perzik, S. L.: Simultaneous Bilateral Radical Neck Dissection with Recovery, Surgery 31:297 (Feb.) 1952.

[12] Ward, E., and Hendrick, J. W.: Diagnosis and Treatment of Tumors of the Head and Neck, Williams & Wilkins Co. 1950.

[13] Crile, G., Jr.: Treatment of Papillary Carcinoma of the Thyroid with Lateral Cervical Metastases, Am. J. Surg. 80:419 (Oct.) 1950.

[14] Horn, R. C., Jr., and Dull, J. A.: Carcinoma of the Thyroid: A Re-evaluation, Ann. Surg. 139:35 (Jan.) 1954.

the neck should be removed together with the primary as indicated.

Lesions of the extrinsic larynx are best treated by total laryngectomy and neck dissection on the side of the primary lesion.

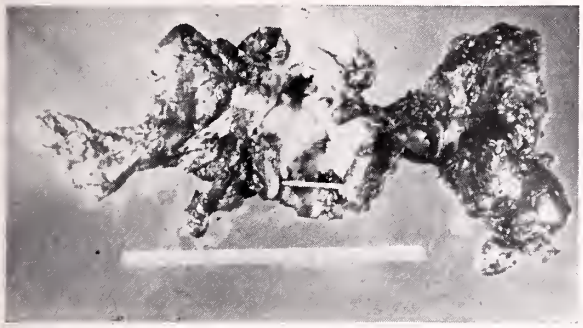


FIG. 8.—Operative specimen from bilateral neck dissection, total laryngectomy, and partial glossectomy for extensive squamous carcinoma originating at base of tongue and involving larynx. Bilateral cervical nodal involvement. Radiation failure.

Other Organ Primaries

No detailed mention has been made of such non-contiguous organ primaries as naso-pharynx, posterior pharynx, maxillary sinus, etc. Briefly, it may be stated that in general the same basic principles governing cancer management elsewhere apply here. Whether radiation therapy or surgery are employed to control the primary disease depends upon the histology and location of the individual lesion. When the primary is known to be under control, or when control is anticipated, neck dissection is the treatment of choice when metastatic cervical nodes are present. If these conditions are not met, strictly palliative radiation therapy directed individually toward palpable nodes is probably all that is justified.

In the absence of palpable cervical node involvement, efforts should be directed toward control of the primary only and no neck dissection done. Obviously these patients must be closely followed and surgery performed (subject to the conditions mentioned above), with the appearance of positive nodes.

Bilateral Neck Dissection

Originally it was thought unsafe to ligate the second internal jugular vein after a neck dissection had been done on the opposite side. Subsequently it became evident that it could be done with safety, and surgeons began doing them in stages.

We know now that a bilateral neck dissection can be done safely at a single sitting.[11,15,16,17] When indicated, it should be done without hesitancy. Furthermore, there are situations which must be considered non-resectable unless a bilateral operation is done — a lesser procedure would transect disease while the more extensive one would encompass all the tumor-healing tissue. Figure 8 shows such an operative specimen.

There is no question that this operation carries some degree of increased morbidity over the unilateral procedure.[15,18,19] But it must be borne in mind that such extensive operations are reserved for desperate situations wherein any lesser operation or radiation therapy has nothing to offer.

Summary

Certain aspects of head and neck cancer therapy are outlined. The adaptability of a standardized neck dissection to the in-continuity dissection of contiguous organ primaries (major salivary glands, mandible, tongue, floor of mouth, tonsil, lateral pharyngeal wall, larynx, thyroid, para-thyroid, esophagus, and skin) is emphasized. Principles governing primary lesions in non-contiguous organs are indicated.

Many of these lesions were formerly considered hopeless. Attitudes of pessimism and defeat are no longer justified and a plea for our aggressive attack against them is fervently offered.

[15] Gius, J. A., and Guier, D. H.: Venous Adaption Following Bilateral Radical Neck Dissection, With Excision of the Jugular Veins, Surgery 28:305 and 319 (Aug.) 1950.

[16] Moore, O., and Smith, R.: A Case of One-Stage Bilateral Neck Dissection with Recovery, Cancer 4:1337 (Nov.) 1951.

[17] Morfit, H. M.: Simultaneous Bilateral Radical Neck Dissection, Surgery 31:216 (Feb.) 1952.

[18] Schweizer, O., and Leak, G. H.: A Study of Spinal Fluid Pressures in Operations Requiring Removal of Both Internal Jugular Veins, Ann. Surg. 136:948 (Dec.) 1952.

[19] Sugarbaker, E., and Wiley, H. M.: Intracranial Pressure Studies Incident to Resection of Internal Jugular Veins, Cancer 4:242 (Mar.) 1951.

Young Hotel Building.

INTERNAL HERNIA

CHARLES S. JUDD, JR., M.D., and ROGERS LEE HILL, M.D., Honolulu

AN internal hernia may present an unusual challenge to a physician. The diagnosis sometimes is not made until after the peritoneal cavity is opened, at the operating table or at post-mortem examination. Such a hernia is confined within the abdominal cavity, and consists of a projection of a sac of peritoneum, containing intraperitoneal structures, through a normal or abnormal opening or structure. The retroperitoneal hernias may be paraduodenal, paracecal, intersigmoid, supravesical, or through the foramen of Winslow. Other internal hernias may be through anomalous or surgically-made openings in the mesentery, mesocolon, omentum, falciform ligament, and broad ligament of the uterus.



DR. JUDD

Of the cases of internal hernia on record, some revealed no symptoms, and were discovered only accidentally. Others gave a history of previous severe acute abdominal episodes, and still others showed vomiting, distension, a palpable mass, shock, and electrolyte disturbances. In general, in the symptomatic cases, manifestations of acute intestinal obstruction appear, and treatment is instituted without the benefit of a specific diagnosis.

If one considers the order of frequency of the causes of intestinal obstruction, it is easy to see why a specific diagnosis is rarely made. McIver[1], in 1932, listed these causes as follows:

Strangulated external hernia	44%
Bands and adhesions	30%
Neoplasm	10%
Intussusception	5%
Volvulus	4%
Mesenteric thrombosis	3%
Gallstones and other foreign bodies	2%
Internal herna	0.9%
Meckel's diverticulum	0.6%
Congenital anomalies	0.6%

Received for publication May 1, 1954.

[1] McIver, M A.: Acute Intestinal Obstruction, Arch. Surg. 25:1098 (Dec.) 1932.

For many years, prior to the introduction of the intestinal decompression tube, an early operation for intestinal obstruction was considered an absolute emergency. In 1931, Wangensteen and his followers perfected tubal decompression of the gut by nasogastric suction. We consider this technical refinement one of the great contributions to modern surgery. We do not subscribe, however, to the practice of its indiscriminate and exclusive use in all cases of intestinal obstruction; We believe that, in the majority of cases, early operation is the procedure of choice in acute intestinal obstruction.

Nemir[2] has reported more recent experiences with intestinal obstruction at the Hospital of the University of Pennsylvania over a ten-year period, (1940-1950). Reference to this statistical survey is made because it reveals typical problems that are usually associated with intestinal obstruction. In Nemir's series, 430 cases of mechanical intestinal obstruction were encountered. Of these, 358 were treated by operation and 72 conservatively. In the operative cases, 142 cases of obstruction were due to adhesions and stricture, against 90 due to external hernias. This reversal of the external hernia-adhesion ratio seems to be rather general. Michel[3] states that there are three reasons for it: (1) More abdominal operations are being performed, with the result that there may be more adhesions being produced, (2) there is a trend toward more and earlier operations for hernia, and (3) workers are being required to submit to preemployment herniorrhaphies because industries will not hire those with hernias.

In Nemir's[2] series, there were 9 cases of intestinal obstruction due to internal hernia subjected to operation. The mortality rate was 22.2%.

There are several theories as to the etiology of internal hernia. Treitz[4], in 1857, and later Lord Moynihan[5]; in 1906, paid great attention to the fossae and folds about the duodenum, cecum, and sigmoid. Moynihan enumerated nine fossae about the duodeno-jejunal junction. He believed

[2] Nemir, P., Jr.: Intestinal Obstruction, Ann. Surg. 135:367 (Mar.) 1952.

[3] Michel, M. L., Jr., Knapp, L., and Davidson, A.: Acute Intestinal Obstruction; Comparative Studies of Small Intestinal and Colic Obstruction, Surg. 28:90 (July) 1950.

[4] Treitz, W.: Quoted by Moynihan.[5]

[5] Moynihan, B. G. A.: Retroperitoneal Hernia. New York, 1906, William Wood and Co.

that these fossae, and abnormal ones resulting from failure of fusion during the third stage of intestinal rotation, developed into openings through which bowel passed to become retroperitoneal. The intestine was said to push a sac of peritoneum ahead of it to form a hernia. Moynihan emphasized laxity of the retroperitoneal tissues and extensibility of the peritoneum as aiding the development of these hernias.

In 1923, Andrews[6] suggested the abnormality of intestinal rotation as a cause of paraduodenal hernia. This has now been widely accepted, and has largely replaced Moynihan's ideas of formation. Andrews believed that, owing to a faulty development of the colon, the small intestine is imprisoned beneath the mesentery of the colon. Normally, in the embryo, the early umbilical loop of gut rotates on its long axis so that the cecum, which lies initially above the umbilicus and a little to the left, crosses over the duodenum and comes to lie eventually in the iliac fossa. Andrews stated that the probable cause of a right paraduodenal hernia is incomplete rotation of the umbilical loop of gut, with abnormal location of the cecum and imprisonment of the small bowel in the large bowel mesentery as the cecum grows to the right. The superior mesenteric artery comes to lie in the free edge of the neck of the sac. Likewise, in the production of a left paraduodenal hernia, Andrews believed that because of minimal rotation or no rotation of the umbilical loop of gut, the cecum lies to the right of the midline, and as the colon grows and elongates and the cecum migrates to its primitive position in the left upper quadrant, the small bowel is caught beneath the mesocolon and comes to lie retroperitoneally. The free edge of the sac contains the inferior mesenteric artery. Callander, Rush, and Nemir[7] feel that the paraduodenal hernias are more suitably named "hernias into the ascending or descending mesocolon."

A third type of paraduodenal hernia has been described by Hansmann and Morton[8]. This is an infraduodenal hernia, and it differs from the right and left types in that its stoma points downward and its sac dissects the peritoneum from most of the posterior parietes.

Zimmerman and Laufman[9] call attention to the fact that anomalous rotation may give rise also to the transmesocolic hernias and to those through the foramen of Winslow.

Hansmann and Morton, in their review of 467 cases, list the incidence of types of intra-abdominal hernias as follows: The left paraduodenal type is the most frequent, and found more in males. The hernia through the transverse mesocolon is next in incidence and found more in women. There follow in order of frequency, right paraduodenal, mesenteric, hernia through the foramen of Winslow, pericecal, intersigmoid, broad ligament, ileoappendicular, ileocolic, prevesical, inferior duodenal, great omental, and ascending mesocolic.

Moynihan's book in 1906 revealed a collection of 74 cases of duodenal hernia, 57 of which were classified as left, and 17 as right. Andrews, in 1923, added 81 cases, only five of which were right paraduodenal. The ratio of the left variety to the right is three to one. Of the right variety, only two were seen at the Lahey Clinic[10] from 1925 to 1944, two at the Mayo Clinic[11] from 1910 to 1939, and one at the Cook County Hospital in a 10-year period[9]. Klob reported the first case in 1861, Neuman the first with successful operation in 1898. Reported mortality rates in operations for right paraduodenal hernia have dropped from 83 to 26% as more series have accumulated over the years[12]. In only a few cases was the diagnosis made preoperatively.

Roentgen films may be an aid very frequently in the diagnosis of internal hernia. Sometimes there is evidence of the intestines' having the appearance of being enclosed in a round sac-like structure or a spherical transparent paper bag. This is sometimes demonstrable by the use of contrast media[13]. The small bowel appears to be in a restricted position, and its coils cannot be disturbed. There is frequently an absence of small bowel loops from the pelvic cavity, and the loops are in close contact. Barium enema may show some distortion of the colon by a loculated mass of loops of small bowel.

Undoubtedly the proper initial treatment is early operation before circulatory insufficiency ensues. Reduction of the hernia is often difficult; the ring cannot be enlarged because of the important blood supply in the neck of the sac. If extreme force is used, tearing of the bowel may be pro-

[6] Andrews, E.: Duodenal Hernia—A Misnomer, Surg., Gynec., and Obst. 37:740 (Dec.) 1923.

[7] Callander, C. L., Rush, G. Y., and Nemir, A.: Mechanism, Symptoms, and Treatment of Hernia into the Descending Mesocolon (Left Duodenal Hernia), Surg., Gynec., and Obst. 60:1052 (June) 1935.

[8] Hansmann, G. H., and Morton, S. A.: Intra-abdominal Hernia, Arch. Surg. 39:973 (Dec.) 1939.

[9] Zimmerman, L. M., and Laufman, H.: Intra-abdominal Hernias Due to Developmental and Rotational Anomalies, Ann. Surg. 138:82 (July) 1953.

[10] Lahey, F. H., and Trevor, W.: Right Paraduodenal Hernia, Ann. Surg. 122:436 (Sept.) 1945.

[11] Mayo, C. W., Stalker, L. K., and Miller, J. M.: Intra-abdominal Hernia—Review of 39 Cases in Which Treatment was Surgical, Ann. Surg. 114:875 (Nov.) 1941.

[12] Collins, D. C.: Right "Paraduodenal Hernia"; Surgical Repair; Recovery, Western J. Surg., Obst., and Gynec. 47:250 (May) 1939.

[13] Reeves, R. J., Moran, F. T., and Jones, P. A.: Right Paraduodenal Hernia with Roentgen Diagnosis and Postoperative Recovery, Am. J. Roentg. and Radium Therapy, 59:338 (Mar.) 1948.

duced. Shock may result from excessive trauma to the bowel. In some cases, resection of ischemic intestine is necessary, with restoration of normally functioning bowel by the means of an anastomosis. The sac is usually impossible to remove, and may be obliterated easily by closing the neck with interrupted sutures.

Case Report

A nine-year-old Chinese-Hawaiian girl was admitted to The Queen's Hospital, Honolulu, on July 16, 1951, with the complaint of dull cramping general abdominal pain of fifteen hours' duration. She had vomited six times, and had had one normal bowel movement on the morning of admission. Except for a cough and sore throat during the two weeks prior to admission, the patient had always been well. There were no previous similar gastrointestinal symptoms.

The temperature was 99.4° F., and the patient appeared pale. The abdomen was rigid throughout, and moderately tender in the peri-umbilical region. There was rebound tenderness, but no masses were palpable. The remainder of the examination was non-contributory. There was no anemia. The white blood count was 21,900 with 80% polymorphonuclear leucocytes and 10% immature forms. Urinalysis revealed no abnormalities.

It was felt that the patient had an acute intra-abdominal condition that obviously necessitated surgery. It was thought that a ruptured appendix was the most likely diagnosis, although the characteristics of the pain suggested an intestinal obstruction. At exploration through a right rectus incision, there was noted a peritoneal opening just below the ligament of Treitz, with a retroperitoneal sac which contained about six feet of proximal jejunum, constricted at the neck. Much of the sac lay posterior to the cecum and mesentery. The small intestine was gently withdrawn, and the sac opening, which was four by two centimeters, was closed carefully with fine silk sutures, care being taken not to injure the superior mesenteric artery which lay to the right of and anterior to the opening. The abdomen was closed in layers with silk. The patient was kept on constant gastric suction for twenty-four hours postoperatively, and made an uneventful recovery thereafter.

It was felt that the hernia was of the right paraduodenal type and that its manifestations were fairly typical.

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GENETIC ANALYSIS OF THE DEAF IN HAWAII

TADAO HATA, M.D., Honolulu

PHYSICIANS familiar with genetic analysis of the deaf from a limited number of pedigrees have concluded that profound deafness is transmitted according to a simple Mendelian scheme. The implication of such a conclusion and its importance from the position of an otologist whose advice is sought are not clearly perceived because of the inherent complexity of the problem of deafness. Deafness can come at all ages and become manifest in several forms.



DR. HATA

A deaf child is one in whom the sense of hearing is non functional for ordinary purposes. The main criterion employed in the actual grouping of this study was whether or not the child ever used articulated speech. The four most important questions asked are: (1) What is the cause? (2) What is the prognosis? (3) Are educational facilities available? (4) Are there hopes for social adjustment?

Diagnosis of a child brought to our attention because of lack of speech development may at the outset be difficult for the reason that there are several possibilities for such a defect. First, a psychological examination of each hard of hearing child is important in order to rule out the mentally retarded, believing as we do that it would be detrimental to group together the mentally retarded with the deaf. A deaf child is usually an alert child.

Second, a child's speech may be delayed due to an emotional cause or lack of incentive to learn.

Thirdly, the child may have some interference in his receptor mechanism so that it would be difficult for him to hear correctly and thus reproduce sounds. The example of the third possibility is a child who is emotionally stable and appears to understand what is said to him but who cannot reproduce sounds or reply as expected. Then there is the child placed in a bilingual environment in the early years of his life who is capable of tolerating the "foreign language of the grandmother" but in a new environment, he is confused with a new language and withdraws from the incentive to learn.

We cannot overemphasize the value of early training of a deaf child, for it is very rarely that a child is born entirely without any response of speech, and the longer he remains without training, the more likely are personality problems to develop. Speech is a function of hearing, and a child who loses his hearing prior to the age of four will, if not trained, definitely become a deaf mute.

Vasomotor rhinitis, to a physician, is considered one of the signs of an exaggerated sensitivity with a tendency on the part of the child to withdraw and to become irritable. Out of an enrollment of 89 this academic year at our Diamond Head School, 39 have been considered as having vasomotor rhinitis. A study of this vasomotor factor is being made, not only as one of the factors predisposing to deafness, but as an indication for training with utmost patience. Here is a child with an allergic load. With yearly examination constructive suggestions are given to over-indulgent parents, as well as to the faculty.

The problem is still far from solved. Nothing gives this better emphasis than the fact that of the 141 children studied, four have been committed to the mental hospital at one time or another for psychiatric care.

Because of the difficulty in making a correct diagnosis, we have made as the first diagnostic objective the determination of whether the lesion responsible for the deafness is or is not in the perceptive mechanism.

What proportion of the group studied can we safely assume were hereditary cases? We know that in some families only one child is deaf, and among small families, this group will form the majority. There are obviously irreparable lesions of the internal ear, and we assume that every lesion of the perceptive mechanism is irreversible and, therefore, incurable. Wishart claims that the "number of patients whose hearing is defective because of a congenital lesion is small. The vast majority are hard of hearing because of disease, usually infection."[1] Scott-Montcrieff has, in his classification of perceptive deafness in childhood, brought out that both congenital and acquired loss

Read before the Ninety-eighth Annual Meeting of the Hawaii Medical Association, Honolulu, May 13, 1954.

[1] Wishart, D. E. S.: A Critique of Present Day Methods of Hearing-Testing. Laryngoscope 63:1045 (Oct.) 1952.

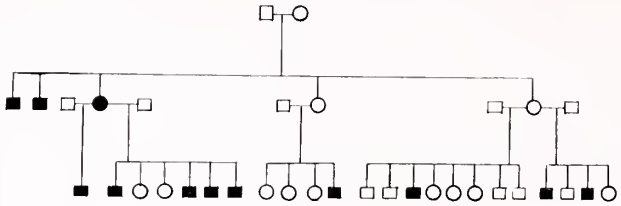


FIG. 1 (Pedigree 1).—In Generation II, of 5 children, 3 are deaf. In Generation III, 9 of 23 are deaf. Chart shows transmission of deafness through simple Mendelian scheme. Note sociological maladjustment.

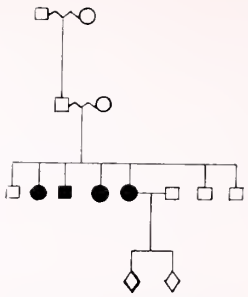


FIG. 2 (Pedigree 2).—Wavy line in Generations I and II indicates consanguineous marriages—resulting, in Generation III, in 4 deaf children out of 7.

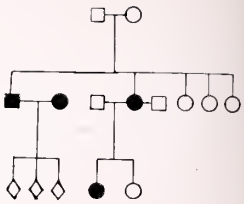


FIG. 3 (Pedigree 3).—In Generation II, 2 out of 5 are deaf. Of 5 children in Generation III, 1 is deaf, 1 a slow learner. Notice sociological maladjustment in Generation II.

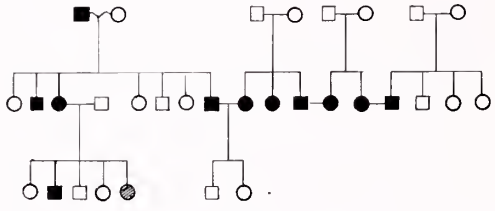


FIG. 4 (Pedigree 4).—Chart shows recessive inheritance in a consanguineous marriage in Generation I. Generation II illustrates the sociological problem of intermarriages among the deaf. Generation III illustrates the role of recessive inheritance in one family where two deaf parents have produced two children with normal hearing.

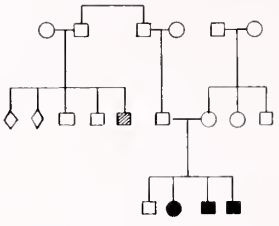


FIG. 5 (Pedigree 5).—Careful medical history of genetic background of children revealed that one first cousin of the children's father was hard of hearing and one brother of the mother was born an imbecile.

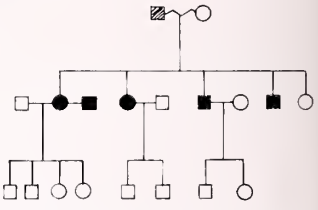


FIG. 6 (Pedigree 6).—A consanguineous marriage between a hard-of-hearing man and a normal-hearing woman produced (Generation II) 1 normal and 4 deaf children. There was no deafness in Generation III. Notice sociological problem in second generation.

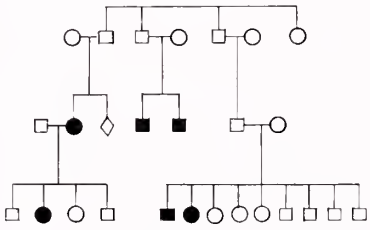


FIG. 7 (Pedigree 7).—Chart shows the value of careful genetic history. Deaf children in Generation III are enrolled at school now. Generations II and III prove definitely that this is a case of hereditary problem and predisposition is definitely toward deafness.

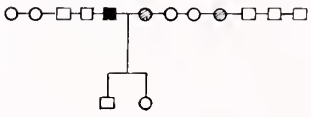


FIG. 8 (Pedigree 8).—Chart shows sociological problem where a deaf man marries a hard-of-hearing girl who comes of a genetic hard-of-hearing family. Two of their offspring are normal.

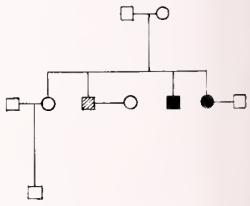
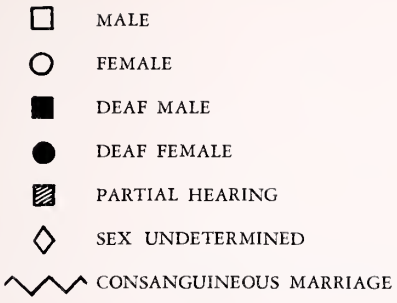


FIG. 9 (Pedigree 9).—An operation for bilateral chronic mastoiditis was performed on a hard-of-hearing male. History later revealed there were two other deaf persons in the family.

SYMBOLS



of hearing are often the result of an epidemic disease, statistics on this varying considerably from time to time and from place to place.[2]

Goodhill has added the significance of the Rh factor and maternal rubella to the etiology of perceptive deafness in a child.[3] Cases of Rh incompatibility are negligible in Hawaii, there having been only 3 cases out of 6,000 deliveries in the past six years in one study series.[4] This would indicate that the Rh factor contributes little toward the cause of loss of hearing among the population in Hawaii.

Bordley, recognizing the need for a comprehensive patient's history, has developed a questionnaire which inquires into: (a) the family background; (b) the prenatal and birth history; (c) the diseases, accidents and operations of early childhood; (d) the general developmental history; including social maturity, and hearing and speech progress.[5]

In presenting the cases, we wish to emphasize the importance of genetic history.[6] The following is an analysis of the 141 cases studied in the past five years with the etiologic factors underlying their impaired hearing.

Congenital spastic paraplegia with loss of hearing (with no known Rh incompatibility)	6
Birth injuries	2
Prenatal rubella	4
Premature birth	3
Serious diseases under one year:	
Chronic otitis media	3
Pneumonia	1
Childhood diseases	11
Cerebral meningitis	12
Streptomycin reaction with tuberculous meningitis	1
Trauma	8
Anatomical developmental anomalies	3
Familial history of deafness	40
Cause undetermined	47

The foregoing figures show that the largest single group is that in which no cause can be determined; the next group consists of children with a hereditary background. The following charts show some of the pedigrees of congenitally deaf children.

Just as a person with a gene for diabetes does not show symptoms of this disease until the critical threshold is crossed, so does a potentially deaf child have enough hearing to pass for a hearing person. There is evidence to believe that in one type of congenital nerve deafness, not distinguishable by audiograms but on the basis of genetic behavior, the child loses his hearing slowly, so that by the age of 10 to 12, he is totally deaf. These types can be distinguished only when two obviously hereditarily deaf persons mate and produce only hearing children. The conclusion is that the cochlear cells are much more susceptible in the very young and deafness is apt to result in a child whose family follows a genetic pattern of loss of hearing.

Figures 1 to 9 clearly indicate the inestimable value of taking complete medical histories of each hard of hearing child. These charts stress the necessity of periodic audiograms in any member of a hard of hearing family who shows signs of infection. Each child's folder should consist of the family history in the form of a pedigree chart for future reference.[7]

At best, no definite answer can be given to the perplexing problem of hard of hearing but this study, if anything, has given us an added stimulus for more research in a child whose family follows a genetic pattern of loss of hearing.

[2] Scott-Moncrieff, R.: Perceptive Deafness in Childhood. Laryngoscope 63:1081 (Oct.) 1952.

[3] Goodhill, V.: The Nerve Deaf Child: Significance of Rh, Maternal Rubella and Other Significant Factors. Ann. Otol. Rhinol. and Laryngol. 59:1123 (Dec.) 1950.

[4] Dr. Richard Sakimoto: Personal communication.

[5] Bordley, J. E.: The Problem of the Pre-School Deaf Child. Laryngoscope 52:514 (May) 1952.

[6] Hopkins, L., and Mecklin, M. T.: Studies on the Inheritance of Deafness in the Pupils of the Clarke School for the Deaf, Laryngoscope 56:570 (Oct.) 1946.

[7] Sortini, A. J., and Flake, C. G.: Speech Audiometry Testing for Pre-School Children. Laryngoscope 63:991 (Oct.) 1953.

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RETROLENTAL FIBROPLASIA

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RETROLENTAL fibroplasia was used by Terry[1,2] to describe what is now recognized as the fully developed or end stage of the retinopathy of prematurity.

Briefly, retrolental fibroplasia is manifest by edema, vascular proliferation, hemorrhages, and retinal separation, occurring in premature infants, usually under four pounds, resulting in partial or total blindness. It may be divided into five "active" grades and five "cicatricial" grades.[3]

Active:

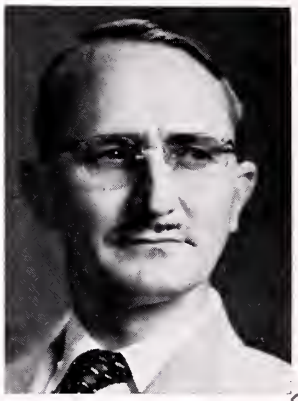
I. Dilation and tortuosity of retinal vessels.
II. Stage I plus neovascularization and peripheral retinal clouding.
III. Stage II plus peripheral retinal detachment.
IV. Hemispheric or circumferential detachment.
V. Complete detachment.

The cicatricial grades consist of varying degrees of scarring in the different stages at which the actual process ceased.

It must be recognized that the normal premature fundus shows a pale nerve head and retina, grey retinal periphery, increased tortuosity of the retinal vessels, and an absence of the foveal light reflex.

Incidence

The incidence of this blinding condition varies considerably from country to country, and even from hospital to hospital. This variability of incidence is probably largely due to lack or inadequacy of examination and to the variation in care given the premature infant. Owens and Owens[4] of Johns Hopkins, who computed the incidence from their extensive survey, state that it occurs in 22% of the infants under 1360 gm. (3 lbs.). The great majority of all cases occur in babies under 1500 gm. (3.3 lbs.). It is rare in infants over 2000 gm. (4.4 lbs.). These figures on incidence relate to the actual presence of a membrane, partial or complete. They feel that, were all cases showing any evidence of retrolental fibroplasia computed, its incidence would be 55% in infants weighing 3 pounds or less.



DR. PINKERTON

In the Territory of Hawaii, of the 36 registered pre-school blind, 23 or 63.8% were due to retrolental fibroplasia.[5] In 1952 the Tripler Army Hospital reported 6 cases, in 1953 5 cases, and none thus far in 1954. All their cases occurred in babies weighing less than 3 lbs. 12 oz. It would appear that there is a definite decrease in incidence.[6] At the U. S. Naval Hospital in San Diego retrolental fibroplasia was found in 16 babies out of 349 (5.9%) prematures weighing less than 5 pounds at birth. Of this group 43% occurred in infants whose birth weight was less than 4 lbs.[7]

Studies of incidence of retrolental fibroplasia as the cause of blindness in pre-school children (under 7 years of age) in the United States reveal that most blindness occurs in the first year or in prenatal life.[8]

The average rate of blindness in 16 states supplying the most complete data was 24.6 per 100,000 population under 7 years of age. Of all cases of blindness, retrolental fibroplasia was the causative factor in almost 50%. In this study a comparison between anticipated and actual number of pre-school blind for 1950 on the basis of the 1943 statistics shows what appears to be a tremendous increase in incidence of retrolental fibroplasia in a seven year period.

It is my belief that although there has been an undoubted increase in the incidence of retrolental fibroplasia, some of this increase is apparent only and not actual, being due chiefly to more frequent

Read before the Ninety-eighth Annual Meeting of the Hawaii Medical Association, Honolulu, May 13, 1954. Slightly revised, and received for publication, Jan. 3, 1955.

[1] Terry, T. L.: Extreme Prematurity and Fibroplastic Overgrowth of Persistent Vascular Sheath behind each Crystalline Lens. I. Preliminary Report, Am. J. Ophth. 25:203 (Feb.) 1942.

[2] Terry, T. L.: Ocular Maldevelopment in extremely premature infants. Retrolental Fibroplasia: General Considerations, J.A.M.A. 128:582 (June) 1945.

[3] Reese, A. B. et al.: A Classification of Retrolental Fibroplasia, J. Ophth. 36:1333 (Oct.) 1953.

[4] Owens, E. C. and Owens, E. U.: Retrolental Fibroplasia in Premature Infants. Progress in Ophth. and Otolary. Vol. 1. Wiener, et al. Grune and Stratton, N. Y., 1953, pp. 143-149.

[5] Bureau of Sight Conservation, Territory of Hawaii.

[6] Lowrey, Jr., Colonel, MC, USA: Personal communication.

[7] Tabor, G. L., Jr., Commander, MC, USN: Personal communication.

[8] Kerby, C. E.: Blindness in Pre-School Children, Sight-Saving Review, Spring 1954.

and careful fundus study and better classification. This opinion is substantiated by the figures showing that the anticipated and actual incidence for *all* causes do not differ too significantly, particularly when the rate of population increase varies.

It is believed that many conditions previously diagnosed as congenital retinal folds, retinal dysplasia, persistence and hyperplasia of the tunica vasculosa lentis, and the various conditions making up the large group of "pseudo-gliomata," were actually retrolental fibroplasia arrested during various phases of development.

Course of the Disease

The earliest changes usually occur between the second and fourth weeks of postnatal life. Cases have been seen during the first week, but rarely before the sixth day if the eyes were normal at birth. Venous dilation occurs in the periphery of the fundus, the arterioles become more tortuous, retinal edema manifest by greyish coloration of the retina develops, and superficial retinal hemorrhages occur, followed by ophthalmoscopically visible neovascularization, retinal elevation, vitreous haze and the production of a greyish membrane arising from the retina and projecting into the vitreous.

The final stage is retinal separation and a complete retrolental membrane due to fusion of the proliferated bands. The process may become arrested at any stage of the disease. Fundus examination during childhood or adult life may show only such phenomena as a marked tilting of the nervehead, high myopia, diffuse retinal pigmentation suggesting an atypical retinitis pigmentosa, a retinal fold, a band of scar tissue, or a fibrous mass in the retinal periphery.

Morphologic Pathology

The earliest changes are found in the nerve fiber layer, and consist of capillary endothelial proliferation producing varicose dilations and budding of the vessels, plus glial cell proliferation. The endothelial cells have abundant cytoplasm and large, pale nuclei. The glial cell nuclei are spindle shaped and stain darkly, and the cells arrange themselves parallel to the retinal surface. It is to be noted that the changes are essentially surface changes and not changes of the deeper retinal substance. As the lesion progresses further, capillary and glial proliferation occur, the capillaries break through the internal limiting membrane of the retina, retinal separation occurs and the retinal bands fuse producing a retrolental mass[9] (Fig. 1).

[9] Text book of Ophthalmic Pathology: A. Acad. of Ophth. and Otolaryng. and the Armed Forces Inst. of Path., W. B. Saunders, Phil., 1952, p. 372.

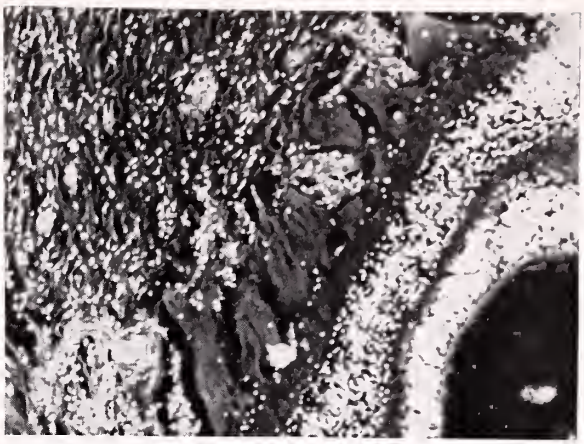


FIG. 1.—Retrolental fibroplasia, showing capillary proliferation, edema and gliosis.

Etiology

Factors relating to the parents: After considering the various causes of prematurity such as multiple births, toxemia of pregnancy, placenta previa, premature placental separation and premature rupture of the membranes, it is the conclusion of numerous investigators that *prematurity itself* and not the cause of prematurity is a significant factor in the etiology of retrolental fibroplasia.

Factors relating to the infant and pediatric management: Neither the season of birth, multiplicity of birth (except where infants are premature), the sex, nor the presence of congenital anomalies seem to be important factors in etiology. The importance of the infant's condition at birth, particularly in regard to prolonged asphyxia and the over-use of oxygen, has been the sphere of considerable disagreement. It is my personal belief that there is more real agreement than disagreement between what appears to be, at least on the surface, two diverging and totally different concepts of the role of oxygen.

Patz[10] has done experimental work on mice, rats, kittens and puppies subjected to 60%-80% oxygen for varying periods, and has produced endothelial nodules in the nerve fibre layer of the retina, budding of capillaries from the retina into the vitreous, retinal edema, hemorrhage and vitreous degeneration. He observed complete obliteration of the retinal vessels after three to four days of oxygen exposure. He feels that anoxia at the cellular level might occur during oxygen therapy as a result of inactivation of oxidative enzymes from prolonged exposure to oxygen.

Ashton[11] has done similar experimental work

[10] Patz, A.: Oxygen in Retrolental Fibroplasia. Tr. Am. Acad. Ophth. and Otolaryng. 58:45 (Jan.-Feb.) 1954.

[11] Ashton, N.: Animal Experiments in Retrolental Fibroplasia. Tr. Am. Acad. Ophth. and Otolaryng. 58:51 (Jan.-Feb.) 1954.

and has produced very similar results. Kittens were used and subjected to 70%-80% oxygen for several days (Figs. 2, 3 and 4). The retinal



FIG. 2.—Retinal vascular tree (India ink injection) of new born kitten before oxygen.

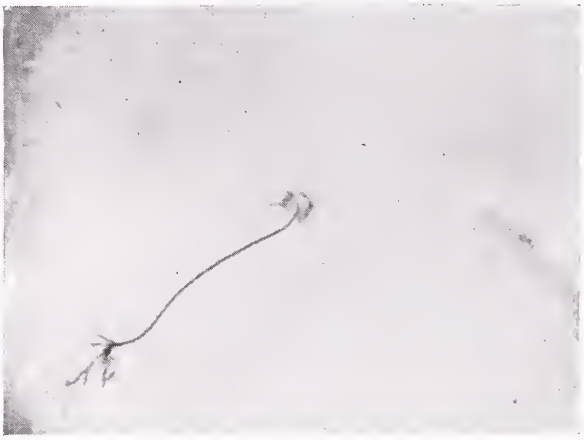


FIG. 3.—Kitten retina after exposure to 80% oxygen. Note complete obliteration of retinal vessels with exception of the more mature hyaloid vessel.



FIG. 4.—Retinal vessels after re-exposure to air. Note the wild vascular proliferation showing lack of normal vascular pattern.

picture was one of massive vasoconstriction of the immature vascular portion, with no effect on the more mature vascular system comprising the hyaloid artery and the vessels of the vascular tunic of the lens. In his animals he has shown that the effect is directly proportional to the degree of immaturity of the retinal vessels, the degree of oxygen concentration and the duration of exposure. He found it more difficult to produce these changes with hypoxia than with hyperoxia. Ashton feels that this vascular obliteration from oxygen over-use produces a more severe hypoxia than can be produced by a low ambient oxygen atmosphere. If the animal was removed from oxygen after prolonged oxygen exposure, a rapid and wild outgrowth of new vessels from the optic disc occurred. It is my experience that, once the disease process develops, oxygen should be given rather than restricted.

Szewczyk[12] feels that retrolental fibroplasia is a terminal phase of anoxic retinopathy produced by oxygen deficiency during a time when the retina is not fully developed and proper vascularization of the retina is lacking. The retina, like the brain and other nerve tissue, has a high oxygen requirement. If there is oxygen deficiency the vessels dilate and edema occurs followed by diapedesis and hemorrhage. Retinal edema appears first in the periphery where the blood supply is deficient. It is his belief that injudicious overuse of oxygen produces a "hyper-reactor" and that unless the premature infant is acclimated slowly to the nursery environment an actual retrolental reaction can be produced.

Szewczyk[13] feels that retrolental fibroplasia is the direct result of retinal hypoxia, either absolute or relative. "Absolute," as a hypoxic insult at birth or from a severe illness shortly thereafter; "relative," as in a child habituated to supplemental oxygen and too suddenly deprived of it, or insulted on several occasions by great variations of oxygen concentration while in an incubator. He cites three cases of hypoxic retinopathy which developed in prematures while in an incubator receiving supplemental oxygen; the nurse in charge had reduced the oxygen concentration too precipitously in two cases, and the other occurred during an upper respiratory infection. Instead of withdrawing oxygen, the oxygen concentration was increased and the infants were kept in oxygen for seventeen weeks. Two became normal and the other developed myopia with distorted discs.

In Szewczyk's experience with 800 premature

[12] Szewczyk, T. S.: Retrolental Fibroplasia. Am. J. Ophth. 35:301 (Mar.) 1952.

[13] Szewczyk, T. S.: Personal communication.

infants he has made a very careful distinction between two groups of prematures, viz: those infants who have suffered no hypoxic insults at birth and those who have suffered hypoxic insults at birth. Of the former group 300 have been studied. They had normal retinovascular systems and did not receive supplementary oxygen. Such a child, even though he contracted a respiratory infection or suffered a severe anemia, would respond by vascular dilation with adequate compensation in supplying oxygen to the retina. Since the retinal vessels had always been normal they would allow no edema or hemorrhage.

An infant of the latter group, who has suffered a retinal hypoxia without supplemental oxygen therapy, does go through a stage of vascular dilation, edema and hemorrhage, but returns to normal in due time. Should this child, however, be the victim of a respiratory infection, severe anemia, or any condition causing the oxygen concentration to fall below requirements, his previously damaged retinovascular tree reacts in an abnormal way. Depending upon the severity of the insult, the retinal reaction may become irreversible. These cases require supplemental oxygen.

Babies who have normal fundi at birth and who do not require supplemental oxygen will not develop hypoxic retinopathy. Babies with hypoxic retinopathy of mild or moderate severity at birth will regress spontaneously and are not liable to develop this disease again if not given supplemental oxygen. Those babies with normal fundi who require supplemental oxygen after birth may not develop any trouble unless acclimatization to oxygen occurs (80% constantly over six to seven days).

If these two groups of babies are allowed to become acclimatized to oxygen and sudden transfer to normal atmosphere, or marked reduction of oxygen concentration is allowed, both will go through the episode of vascular dilation and edema, but the latter group (those subjected to hypoxia at birth) may progress to retrolental fibroplasia, while the former (those not traumatized by hypoxia at birth) will usually get well. If both groups are replaced in high oxygen concentration, regression will occur. Sudden transfer again to normal atmosphere will then produce a violent response with greater severity in the hypoxic babies and rapid progression, sometimes irreversible even with high oxygen concentration, will occur.

An oxygen acclimatized child can be acclimated to normal atmosphere by a very, very slow process of oxygen reduction or his oxygen carrying capacity can be increased by transfusions. Transfusions should not, however, be given to a baby after hypoxic retinopathy develops because this increased volume increases the edema and extravasation and the latter acts as a barrier to proper oxygen absorption.

Szewczyk cites many mechanical difficulties in maintaining proper oxygen control such as leaks in valves, tubing, accidental disconnections, fall in pressure of oxygen tank affecting the liters of flow entering the incubator, unreliability of flow valves, etc.

Prevention

Judicious use of oxygen only when needed, and then only in concentrations necessary for the child's general condition, should be the constant thought of pediatricians and supervisors of premature nurseries.

Summary

Retrolental fibroplasia has been described and classification of the various stages has been given. Morphologic pathology is that of endothelial proliferation, neovascularization, edema, and retinal separation. The process is often reversible in the earlier stages. It has greater tendency to develop in premature infants under four pounds in weight at birth.

Oxygen produces vascular obliteration in certain experimental animals, when used in high concentration. Oxygen should not be routinely used in premature infants for it is believed that an actual sensitization or acclimatization occurs and unless very gradual withdrawal of oxygen is carried out a relative retinal anoxia may be produced, with actual production or stimulation of the pathologic process of retrolental fibroplasia. Oxygen sampling of the incubator air near the infant's head, using the oximeter method and percentage estimation rather than depending on liters per minute of oxygen flow, would be desirable. Oxygen should never be given to a premature infant unless it is specifically indicated, and then only in amounts just adequate to maintain proper color.

Fundus study of all prematures below four pounds in weight one week after birth is highly recommended. Should a premature, normal at birth, require supplemental oxygen for more than seven days, very slow reduction of oxygen over a period of at least one week is recommended, or if not contra-indicated, a blood transfusion. A fundus study should be done at the end of that time. A child with severe hypoxia at birth should have a fundus examination immediately before,

during, and after oxygen therapy. A child suffering severe hypoxia at birth should never have a transfusion until fundus examination has ruled out the presence of active or incipient retrolental fibroplasia for the reason that an overloading of the vascular system might cause an increase in the retinal pathology. A baby, particularly one who has had hypoxia and who has required the repeated use of oxygen, has likely been sensitized to oxygen and should be watched carefully for signs of retrolental fibroplasia.

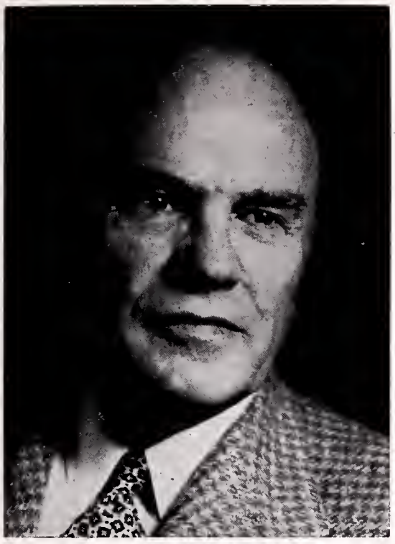
In a recently reported series (July 1954)[14] of experiments on kittens in which the retinal vessels were actually photographed through a limbal window the following conclusions were made: a. In the kitten immediate and delayed reactions are seen. The former consists of vasco-constriction and capillary obliteration developing after five minutes' exposure to 80-90% oxygen. The vessels reopen after ten minutes and remain in this state for about five and one half hours, when the delayed effect comes on. Total vasco-constriction gradually develops, becoming complete in about eight hours. Once this is achieved the circulation may be opened or closed in about five minutes by alternating air and oxygen.

[14] Ashton, N. & Cook, Direct Observation of the Effects of Oxygen on Developing Vessels, Brit. J. Ophth. 38:433 (July) 1954.

Young Hotel Building.

For my part, I approve of paying attention to everything related to the art, and that those things which can be done well or properly should all be done properly; such as can be quickly done should be done quickly; such as can be neatly done should be done neatly; such operations as can be done without pain should be done with the least possible pain; and that all other things of the like kind should be done better than they could be managed by the attendants.

— HIPPOCRATES
On Regimen in Acute Diseases



NILS P. LARSEN, M.D.

The President's Page

Recently some of us saw a film, developed by the American College of Physicians and paid for by the Wyeth Co., on "Hypertension." It was presented by four professors who told their experiences with the new drugs for this very common malady. The highlights that registered with me were:

(1) How quickly ideas in this field have changed in recent years. (2) These doctors indicated that hexamethonium and apresoline were on the way out since the toxic symptoms were a little too difficult to control, although in some cases the blood pressure control was very dramatic. (3) The present "fair haired" therapeutic agents seemed to be rauwolfia and pentolinium. The combination semed to be very effective although they were of no use in the very severe cases with azotemia. (4) It was very important to calculate carefully the dose needed to control the pressure and when the control, especially with the addition of pentolinium, became quite stable, salt restrictions did not have to be as severe as at the beginning. (5) The statement by one of these professors that now for the first time we could present a very hopeful regimen for every case of hypertension, seemed a real step ahead. (6) The patient should be taught to take his own blood pressure the same as a diabetic is taught to do his own urine analysis. The pressure could thus be kept under control almost as accurately, and more accurately for therapy since the pressure taken in a doctor's office is often not a true basic value. (7) The fact that the eyegrounds improved suggested that real changes occurred in the basic pathology. (8) The relief of distressing symptoms was quite constant and made these patients particularly grateful. (9) Hypotensive symptoms were sometimes useful in determining the exact dosage on which the patient should be maintained.

The whole program was delivered on a very hopeful note. Since hypertension occurs over many years before the first symptoms, it seems the only way we can get the potential candidates, will be on doing annual physical examinations or with surveys of large organizations. The hope of course is, if these symptomless cases can be started on therapy, then tissue damage will not occur and perhaps many of the tragedies from blood vessel strain can be prevented. If a large number of our members could do a united study on this problem, we could perhaps verify the truth or falseness of those statements. The correct answer should show up more quickly than under the ideal conditions seen in a university research setup.

I believe that community research by a large number of doctors will give a better answer more quickly as to the strength and weaknesses of any new therapy.

Nils P. Larsen

Hawaii
MEDICAL JOURNAL

OFFICIAL PUBLICATION OF THE
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[EDITORIALS]

TV Health Education

Health education via television was begun over a year ago by the Health Education Committee of the Hawaii Medical Association. Three or four members each month have participated in a "live" TV program, after from ten to sixteen hours of preparation and rehearsal time.

Cancer, rheumatic fever, accident prevention, coronary heart disease, physical examinations, diabetes, allergy, skin diseases, and pregnancy, labor and delivery are the subjects which have been presented this past year. The dual approach has been to present important information for the public on the subject, together with some understanding of the doctor's role and how to be helpful to him. Public relations for the medical society, then, is an integral part of every program.

KONA-TV has made public service time available to the society for the past 8 programs. In addition they have worked patiently with each program, and directed studio rehearsals to a degree not to be expected in a public service program. The interest of the personnel of KONA, from the cameraman to the manager, alone makes the work put into such programs seem worthwhile.

Assistance has been freely given by other community agencies. Jeanne Paty, health education consultant of the Territorial Department of Health, has given the committee the benefit of her services and her experience in television, and has also furnished most of the visual aids for the programs. During the cancer program the Hawaii Cancer Society offered its assistance.

The Health Education Committee is coming to a crossroad. One fork leads to a dead-end street, with a few more programs on the same pattern before this work is dropped. On the other street, increased interest and support in this work could mean better programs and a larger audience.

The committee cannot continue to function satisfactorily by wondering how they can secure the materials necessary for each program. The time put into each program should assure the society of a sizeable audience. This can be done only through various means of advertising each program. The newspapers have given small releases to announce each program, but this must be supplemented by attention-getting display ads. Other means of promotion are also possible with minimum expense. At the present time the committee isn't even operating on a shoestring, but mostly on the goodwill of a few citizens whose generosity has its limits, and on whom the society cannot continue to make demands. The budget request of this committee for the next year is one which will, we expect, carry it on the road of expanded programming and wider viewing.

Television as an educational medium has barely been explored. The fact that it combines sight, sound, and motion makes it a compelling force of communication. We in Hawaii are pioneers in local educational programming. Commercial firms recognize the selling power of TV. In medicine we may sell more knowledge on health, and better understanding of the doctor's role with his patient, and the doctor's role in the community.

KATHERINE J. EDGAR, M.D.
Chairman,
Health Education Committee

Cancer Society Needs Your Support

The excellent support (both moral and financial) which the physicians of Hawaii have given to the Cancer Society has made it possible for the Society to develop outstanding programs.

Because of medical participation in the actual work of the Cancer Society, it has enjoyed a very high degree of respect from the community at large and has thus had little difficulty in getting support from other professional groups as well as from the public. And what is more important, the Society has been able to meet the needs of practicing physicians far more adequately in the way of furnishing cytologic assistance in cancer detection and postgraduate education than would have been possible without the interest, guidance and cooperation which have been extended.

The public education program of the Cancer Society has stimulated laymen to have regular cancer detection examinations and to consult their private physicians when symptoms which might mean cancer have developed. This program of early detection and early treatment of cancer is possible only with physician cooperation.

The cancer morbidity study sponsored jointly by the Medical Societies, the Territorial Health Department and the Cancer Society has produced valuable leads for cancer research. A study is now being planned on cancer of the stomach in Japanese men. We hope this study will reveal information on the cause of cancer of the stomach in all people. The report by Dr. Ian Macdonald titled "Factors Affecting the Biological Behavior of Gastric Carcinoma" found elsewhere in this issue gives information which may assist in this study. The first question to be considered is, what is the stimulus (or stimuli) which causes the human stomach to respond biologically by developing a cancer? The next logical question is, why do Japanese men receive more of these stimuli, or why do they respond more vigorously to the stimuli than do other men?

Funds will be solicited by the Hawaii Cancer Society again in May this year for the continuance of all these life-saving activities. The support of every physician is needed.

WALTER B. QUISENBERRY, M.D.
Executive Director
Hawaii Cancer Society, Inc.

Nursing as a Career

Most of us realize that the so-called "shortage of nurses" is due not to a smaller number of women entering the field, but rather to the increased need and demand for nursing services in new and widespread areas. Actually, we have more nurses today than ever before, and more students are enrolled in our schools of nursing than at any other period except during the recent war years.

Doctors more than any other persons in the community (except nurses themselves) are apt to be asked by young women for information concerning a career in nursing. These questions might range from information concerning a girl's potentialities for nursing to a request for information about a particular school of nursing. I am sure the following questions sound familiar to most of you: Do you think I could be a good nurse? How do I make the initial application to a school of nursing? What are the names of the schools of nursing in this area? What are the high school requirements for entrance into a school of nursing? Certainly doctors can, with their interest in the maintenance of adequate supply and quality of nursing care, be a great ally in assisting with the problem of encouraging young women to explore the possibilities in the field of nursing. A doctor could well be responsible for a girl's beginning interest through early medical care or office visits, and is in a very favorable position to help kindle such ambition.

In addition to the information that doctors have at hand, there is other help to be obtained from the Careers Committee of the Hawaii League for Nursing. This group is responsible for disseminating information about nursing as a career, as well as for furnishing names and addresses of schools of nursing in the Territory and on the mainland. This committee is interested in encouraging qualified young people to enter nursing—professional or practical—and is appreciative of the assistance that members of the medical profession can give. For further information concerning how doctors can help, or where a person can get additional information, ask Mrs. Alice Scott (phone 50-1731), Chairman Careers Committee, Hawaii League for Nursing, Territorial Department of Health.

MRS. STELLA ROBINSON, R.N.

This is What's New!

Primary carcinoma of the liver may be due to a **deficient diet.** A world survey of this disease indicates that the incidence is low in people on an adequate diet but high in areas where the diet is low in protein, certain B complex vitamins and fats. Does this explain the high incidence of primary carcinoma of the liver among local Filipinos? (Berman, paper presented before the New York Cancer Society October 5, 1954.)

* * *

Arizona scorpions pack much more of a wallop than their Hawaiian cousins. Two species of scorpions in Arizona caused twice as many fatalities over the past twenty years as all other poisonous animals, including Gila monsters, rattlesnakes, and black widow spiders. (Ressmann, Southern Medical Association Meeting, St. Louis, Missouri, November 8-11, 1954.)

* * *

Is **histamine gastric analysis** a helpful screening method in early diagnosis of **gastric cancer?** Wirts of Jefferson Medical College screened 1258 patients for achlorhydria after histamine administration. Of the group with achlorhydria, only one patient was found to have an asymptomatic carcinoma of the stomach. A partial gastric resection was performed. At time of operation a metastatic nodule was seen in the liver. The patient was doing well four months postoperatively. The author concludes that while the results were hardly sufficient to justify great enthusiasm, this test has some value as a screening method preliminary to an upper gastrointestinal series. (*Am. J. Med. Sci.* 229:1 [Jan.] 1955.)

* * *

Constricting or aneurysmal lesions of the thoracic aorta, whether they be arteriosclerotic, congenital, syphilitic, or traumatic, are being cured surgically. Cooley and DeBakey of Texas have replaced the diseased portion of the descending thoracic aorta with **homografts.** Twenty-one patients were treated in this manner with an operative mortality of slightly less than 15 per cent. In general the results were excellent, with surprisingly few neurologic sequelae. (*Thoracic Surg.* 29:66 [Jan.] 1955.)

* * *

In the same journal on page 37, Kirkland of the Mayo Clinic reports surgical cure of **interatrial septal defects** by merely [!—Ed.] plugging the puka with a **plastic sponge** and suturing it in place. Connective tissue from the septum invades the sponge to hold it in place and the surfaces are then endothelialized.

* * *

A group of physicians in Philadelphia attempt to answer the patient's question, "Will the valve close again after **mitral commissurotomy?"** Answer: No, at least not in 600 patients who have had the procedure done during the past five years. (*Circulation* 11:14 [Jan.] 1955.)

* * *

A **large dose of propylthiouracil** (two to three times the usual dose) is **more effective** and **more toxic** than a smaller, conventional dose. Bartels and Kohn at Labey's gave up to 1 gram of propylthiouracil a day. They found that thyrocardiacs showed the most striking response to the bigger dose. (*J. Clin. Endocrinol. & Metab.* 14:1403 [Nov.] 1954.)

* * *

Greater use of contrast media and **serialographic examination** have been the most noteworthy advances in **diagnostic x-ray** in the past year. Ureteral peristalsis can be observed by taking numerous exposures of the urinary tract as the dye moves from kidney to bladder. Such serialographs aid in diagnosis or exclusion of small strictures and tumors. (*Public Health Reports* 69:1017 [Nov.] 1954.)

FRED I. GILBERT, JR., M.D.

Perhaps It's Your Nerves

Psychiatric Experiences at Oahu Prison

Psychiatrists on the staff of the Territorial Hospital provide psychiatric consultation services to other institutions in the territory. A brief description of such a service at Oahu Prison is presented.

Following are several hypothetical cases—types of patients who might have been seen at Oahu Prison in psychiatric consultation. In each case a possible disposition is suggested:

(A) A young inmate has been talking and laughing to himself for months. The consultant is requested to evaluate his mental condition, and the possibility of transfer to Territorial Hospital for treatment. This patient is dull, untidy and apathetic. He admits hearing voices, which he may have requested voluntary confinement to escape from. He does not believe he is sick and does not respond favorably to the suggestion that he might be better off in a hospital. This helps to differentiate him from the occasional malingerer who pleads for transfer to get away from the prison.

Disposition: After a trial of sedation and supportive therapy, this inmate is transferred to Territorial Hospital for treatment.

(B) A young inmate requests an interview with the psychiatrist. He does not wish to discuss the matter with the referring officials. At interview he is a bland, impassive individual who wonders glibly if psychotherapy might help him stay away from heroin when he leaves prison two years from now. He is invited to participate in follow-up interviews or group sessions, with the idea that it might do him some good to express his difficulties to the therapist or in the company of other addicts. He fails to keep his next appointment. This is doubtless due to a lack of real anxiety to motivate the effort.

(C) A middle-aged inmate petitions the Parole Board yearly for his release from prison. This year, as usual, the authorities send him to the psychiatrist for evaluation in anticipation of his yearly appearance before the Parole Board. He returns several times for interviews, is experienced in answering the usual questions relative to his past behavior and present mental status. He asks the consultant to certify that he will never disobey the law again. With the aid of psychological tests done by psychologists from the University of Hawaii, the consultant writes a letter to the Board which includes only a short personality inventory and a statement of opinion as to whether inmate is at present free of major mental illness.

(D) A young ex-merchant seaman asks for psychotherapy because a year ago, while intoxicated, he assaulted a nine year old girl sexually. He shows great signs of remorse and wishes, on the advice of his lawyer, to be transferred to Kaneohe. He mentions suicide in the first interview, and as he leaves the room smiles winningly and says, "You'll do all you can to help me, won't you, Doc?"

Disposition: Request for transfer is denied as pleasantly as possible. Continuing interviews are offered. Inmate is seen five or six times and proves to be a typical psychopath, with little real feeling for anyone and absolutely no idea of entering sincerely into a psychotherapeutic relationship. He is encouraged to see the psychiatrist weekly but slow progress is made and after a time he fails to keep his appointments. He manages to meet the doctor in the hallway almost every week, at which time he acts as though he had not seen the doctor for months and is very pleased to have this chance for a chat. All ideas of psychotherapy are dropped.

(E) Rarely, a young man suffering from an anxiety reaction which is treatable with short-term intensive psychotherapy desires to see the psychiatrist, gains almost immediate relief from his tension and is cooperative in keeping his appointments. He seems to develop insight rapidly into his problem in a few interviews. He forms a good relationship with the therapist, and the latter is pleased because of this opportunity to use some of his knowledge of psychodynamics. After nine sessions, the patient feels much better. The psychiatrist suggests that he would be glad to see patient from time to time if any further problem presents itself but that there is no further need for regular weekly sessions. This inmate may refer himself for a refresher session or two but is essentially considered as having benefited from the short period of psychotherapy.

In one year (from July 1, 1953 to June 30, 1954) the psychiatric consultant to Oahu Prison held a total of 315 interviews. Ninety-four of these were short, ten-minute "Camp Clearance" procedures, to rule out obvious neurotic or psychotic processes in inmates who were about to be sent to Kulani or Olinda Projects, prison camps on the outlying islands.

The remainder of the consultant's time at Oahu Prison was spent with 98 different inmates, who were seen in a total of 221 interviews. No accurate diagnostic classification could be constructed from the available data because many inmates were seen once, briefly, and not referred again. It was obvious that several prisoners referred were schizophrenics; many of these had formerly been committed to Territorial Hospital. Of sixteen psychotics, most were labeled schizophrenic reaction, paranoid type. One of these was a woman.

Twenty inmates fell into a miscellaneous group of near-normals, addicts, alcoholics, neurotics and homosexuals.

Sixty-two inmates, including two women, were clearly members of that group known widely as "psychopathic personalities." This term has been replaced officially by that of "antisocial person-

(*Continued on page 356*)

Woman's Auxiliary

The annual business and election meeting held in December brought to a close the sixth organizational year of the Woman's Auxiliary to the Honolulu County Medical Society. Under the chairmanship of Mrs. John William Devereux, the Constitution Committee accomplished a complete revision of the Constitution and Bylaws, providing a better working code for the officers and allowing the annual meeting to be held in December in accordance with the change in calendar recently adopted by the Honolulu County Medical Society.

OFFICERS FOR THE YEAR 1955

Mrs. P. Howard Liljestrand	President
Mrs. Homer Benson	President Elect
Mrs. Robert Johnston	Vice President
Mrs. George Garis	Recording Secretary
Mrs. Louis Buzaid	Corresponding Secretary
Mrs. Albert Ishii	Treasurer
Mrs. J. Warren White	Historian
Mrs. Joseph Lam	Member-At-Large
Mrs. Joseph Lucas	Member-At-Large
Mrs. Theodore Tomita	Auditor

A drive for new members was well under way by the close of the year, and membership to date numbers more than two hundred. One important factor contributing to an increase in membership was the innovation of the quarterly newsletter patterned after that of the Hawaii Medical Association and carrying the president's message, as well as current topics of interest, to all members and prospective members. The newsletter is also sent as a courtesy to the presidents of the Auxiliaries of the neighbor islands.

This has been a year of Conventions, and the Auxiliary has contributed much to their successful outcome. Although some of the results accomplished have been credited officially to the Auxiliary to the Hawaii Medical Association, the work was done largely through the membership of the Honolulu County Auxiliary, due to the fact that the conventions were held on this island. The five conventions meeting here during the past year were: the Hawaii Medical Association, the post–American Medical Association tour, the Pacific Coast Oto-Ophthalmological Society, the New Orleans Graduate Medical Assembly, and the Pan-Pacific Surgical Congress.

The American Medical Association Convention is to be held in Atlantic City from June 6 to June 10 this year. Scheduled for May and June will be four official grand medical tours to Europe from New York. Two pre-convention tour departure dates have been arranged for May 6 and May 8: two post-convention tour departure dates have been arranged for June 11 and June 13. Cities in France, Italy, Germany, England, Switzerland, and Holland are on the itineraries. The American Medical Association has designated United Air Lines to be its official carrier. United will make all arrangements in connection with the European tours from Honolulu. Inasmuch as United does not fly the Atlantic, arrangements will be made with regularly-scheduled trans-Atlantic carriers, offering first class transportation and holding proven records of competency. A new and interesting side line presented to its women passengers by Sabena Belgian Airlines is membership in the unique *Lady Sabena Club,* recognized as the world's first "petticoat" travel club. The cost of the tour per person will be $1598 from New York. Medical meetings will be held in Paris, Rome, Zurich, and London.

Today's Health

The Auxiliary has set as a goal this year the promotion of the distribution of *Today's Health*, a monthly magazine published by the American Medical Association. As specified by the American Medical Association, the Auxiliary is the *only* authorized agency for the distribution of the magazine in the Territory. Mrs. I. L. Tilden, Chairman, has announced that a six-month complimentary subscription was sent to every doctor and dentist during the past year. In following through on the National program, Mrs. Tilden has organized an extensive campaign working toward one hundred per cent subscriptions for doctor's offices. Rates for doctors are half the cost of rates for the regular subscriptions. Expansion of circulation through public and private organizations will follow as a means of promoting better public relations for the medical profession and presenting excellent informative material on health education to the public.

MRS. L. L. BUZAID

Bureau of Medical Economics

Monthly Statements??????

Does your office use accepted and tried procedures in exacting payment for your services? If you cannot truthfully give a quick answer of "yes" then your system of billing should be looked into.

In the average practice a doctor will send out 100 to 500 statements each month. In mass form such as this, is it any wonder that at times the physician loses sight of the fact that each and every statement will receive the scrutiny of an auditor? Is the balance carried forward correct? It had better be, because if it isn't here is the first of a series of excuses for non-payment. Is this the first billing for this charge? If so, let us hope that you have included an itemized statement, because if you haven't, your patient will think up all sorts of excuses for not paying this bill. Let me give you an example of what may have transpired between a husband and his wife. Wife: "Dear, I went to the doctor's office today for this let down feeling I've been having lately." Husband: "What did he say was the matter?" Wife: "He said I had a virus of some kind." Husband: "Well, it could be worse, it seems that everything nowadays is labelled a virus." Then comes the first of the month and your statement to the patients reads as follows: For professional services rendered—$14.00. Husband: "Golly, this quack must be trying to buy another Cadillac. Imagine charging $14.00 for an office visit! He just can't do this—I won't pay it. Most doctors will charge only $3.00 or at the most $5.00 for an office visit." Wife: "It does seem unusually high." Husband: "Just be sure you never go back to him."

To make a long story short, this account was finally referred to the Bureau of Medical Economics for collection. The account was now thirteen months old, which meant that the following direct expenses had been incurred.

Stamps	$ .42
Envelopes	.09
Statements	.11
Labor	1.50
Miscellaneous	.25
Total	$2.37

Now you have $11.63 left for overhead, drugs and services. But you have now referred the account to a collection agency. If you referred it to the Bureau you would have lost another 33⅓% which left you only $6.96. *If you referred* it to a commercial collector who charged 50%, you would only have $4.63 left out of the $14.00. When this patient's husband came into the Bureau office he was both angry and bitter. I called the doctor and received a breakdown on the charges—$4.00, Office Visit; $2.00, Injection; $5.00, Laboratory; and $3.00, Medicine. Total, $14.00. After spending over thirty minutes with this gentleman he finally agreed to pay the bill and went away in a better frame of mind. (Only your Bureau can afford to spend this kind of time with your patients.)

The Bureau makes the following recommendations:

1. **Be certain that you itemize the charges on the original bill and take great care in accuracy—this is important.**
2. ***Bill monthly to every patient.**
3. **Send a reminder on the third mailing.**
4. **Send a stronger reminder on the fourth mailing.**
5. **Send a personal letter on the fifth mailing.**
6. **Use the Bureau sticker on the sixth mailing which reads as follows:**
   †"The doctors of Honolulu County have adopted a policy whereby past-due accounts are to be turned over to our Bureau of Medical Economics for collection. Since your account is past-due we will be required to turn it over to the Bureau for collection unless settlement is made prior to....."
7. **At the end of six months refer the account to the Bureau for collection. Once you warn a patient, be sure you follow it up.**

* Statements should be mailed so that they arrive at the patient's home on the 31st or 1st of the month.
† Available from the Bureau at no cost.

The Bureau of Medical Economics through its collection work not only solves collection problems, but also prevents economic crises. People have been induced to pay their bills with a minimum of threats. Settlements are almost always amicably made and lawsuits are a rarity. Remember, it is not the doctor's bill which causes economic hardship but the car payments, the TV installments, the loan company and the bank payments. It is when the doctor asks for payment of his bill in addition to their other payments that a financial crack-up is inevitable. At a time like this the patient needs help and the Bureau is equipped to give the necessary aid.

Future Plans

The Bureau of Medical Economics is now planning a "Professional management division"

(*Continued on page 356*)

The Honolulu County Medical Library

MRS. ETHEL HILL, *Librarian*
MRS. CORALE BORGES, *Library Assistant*
Phone 6-5370
8:00 a.m.-4:30 p.m., and 7:30 p.m.-9:30 p.m.
Monday through Friday
Closed Saturdays at noon and Sundays
Closed all day and evening on National holidays
and at noon on Territorial holidays

Recent Acquisitions

Cancer

Gregory, J. E. *Pathogenesis of cancer.* 2nd ed. c1952. (gift of publisher)
Steiner, P. E. *Cancer: race and geography.* c1954.

Clinical Medicine

Chatton, M. J., ed. *Handbook of medical treatment.* 4th ed. c1954. (gift of publisher)

Endocrinology

Black, B. M. *Hyperparathyroidism.* c1953. (gift of publisher)
Escamilla, R. F. *Laboratory aids in endocrine diagnosis.* c1954. (gift of publisher)
Pincus, Gregory, ed. *Recent progress in hormone research.* v.10. c1954.
Starr, Paul. *Hypothyroidism.* c1954. (gift of publisher)

Hematology

International Society of Hematology. *Proceedings . . . 4th international congress. Mar del Plata, Argentina, Sept. 20-27, 1952.* c1954. (gift of publisher)
Kauvar, A. J. *Hypoglycemia and the hypoglycemic syndrome.* c1954. (gift of publisher)

Hospitals

Commission on Financing of Hospital Care. *Financing hospital care in the United States.* c1954. (gift of the Commission)

Kidneys and Liver

Fishberg, A. M. *Hypertension and nephritis.* 5th ed. c1954. (gift of publisher)
Lichtman, S. S. *Diseases of the liver, gallbladder and bile ducts.* 2 v. 3rd ed. c1953.
Schiff, Leon. *Clinical approach to jaundice.* c1954. (gift of publisher)

Neurology and Psychiatry

Association for Research in Nervous and Mental Disease. *Genetics.* v.33. 1954.
Bonica, J. J. *The management of pain.* c1953. (gift of publisher)
Dublin, W. B. *Fundamentals of neuropathology.* c1954. (gift of publisher)
Dunbar, Flanders. *Emotions and bodily changes.* 4th ed. c1954. (gift of publisher)
Pottenger, F. M. *Symptoms of visceral disease.* 7th ed. c1953. (gift of publisher)
Robinson, M. F. *Psychosurgery and the self.* c1954. (gift of publisher)

Obstetrics and Gynecology

Burch, J. C. *Hysterectomy.* c1954. (gift of publisher)
Jones, G. S. *The management of endocrine disorders of menstruation and fertility.* c1954. (gift of publisher)

Ophthalmology

Lyle, D. J. *Neuro-ophthalmology.* 2nd ed. c1954. (gift of publisher)

Orthopedic Surgery

Bateman, J. E. *The shoulder and environs.* c1955. (gift of publisher)
Smith, F. M. *Surgery of the elbow.* c1954. (gift of publisher)

Pediatrics

Green, Morris. *Pediatric diagnosis.* c1954. (gift of publisher)
Stephen, C. R. *Elements of pediatric anesthesia.* c1954. (gift of publisher)

Surgery

Atkins, H. J. B. *Postoperative care.* 4th ed. 1951. (gift of publisher)
Beneventi, F. A. *Retropubic prostatectomy.* c1954. (gift of publisher)
McVay, C. B. *Hernia.* c1954. (gift of publisher)
Medico-surgical tributes to Harold Brunn. c1942. (gift of Mrs. Schattenburg).
Parsons, Langdon. *An atlas of pelvic operations.* c1953. (gift of publisher)

Miscellaneous

Albritton, E. C., ed. *Standard values in nutrition and metabolism.* c1954. (gift of publisher)
Major, R. H. *A history of medicine.* 2 v. c1954. (gift of publisher)
Quarterly cumulative index medicus. v.45, Jan.-June, 1949. c1954.
Waife, S. O. *The doctor writes.* c1954. (gift of publisher)

* * *

The December, 1954 issue of *Postgraduate Medicine* was devoted to papers by doctors from the Straub Clinic. Dr. Harry L. Arnold, Jr. was Guest Editor for this issue, and Drs. Strode, Carty, White, Burgess, Ewing, Lowrey, Myers, Bowles, Waite, Freeman, McCorriston, Palma, Hartwell, Tilden, Cowan and Arnold, Jr., all were contributors.

* * *

Drs. Civin, Gotshalk and Okazaki have published an interesting article on "Histiocytic Medullary Reticulosis" in the September, 1954 issue of the *Archives of Internal Medicine.*

It is our intent to call attention in these columns, to all papers published by our own members. However, we may overlook some articles in our hasty scanning of the current journals. We would greatly appreciate being advised of such publications, and would also be pleased to receive reprints for our files.

Book Reviews

The Management of Endocrine Disorders of Menstruation and Fertility.

By Georgeanna Seegar Jones, M.D., 198 pp., Price $5.75, Charles C. Thomas, 1954.

To any practitioner, including postgraduate gynecologists, having a special interest in gynecological endocrinology, this small volume will be of great value. It is compact; it is well-presented; and it embodies all of the essential facts known about the pituitary, chorionic, and ovarian hormones, in addition to a pertinent, up-to-date discussion of the problems and management of all of the various types of so-called "functional uterine bleeding." It should be reviewed by all who attempt to treat cases falling into this category.

LAURENCE G. THOUIN, M.D.

Neuro-ophthalmology.

By Donald J. Lyle, M.D., Second Edition, 591 pp., illustrated, Price $17.50, Charles C. Thomas, 1954.

This text, written by one of the leading ophthalmologists in the country, is an excellent work dealing with a very complex subject. It is indeed not easy to present such material to the average ophthalmologist unless he has devoted much time and effort to the neurological aspects of his specialty. The text deals with the relationship of the eye to the brain, showing the effect of certain diseases of the brain on the eye. The author has portrayed by pen and picture the related neurologic and ophthalmologic aspects of intracranial lesions and has correlated the same by collateral anatomical diagrams and photomicrographs, x-ray photographs, visual fields and fundus photographs. The subject has been presented in such an interesting way that all ophthalmologists should be stimulated to take a more detailed interest in neurology in their everyday practice. The two fields are inseparable and should be so considered in every eye problem. The text is a great credit to the author and a significant addition to one's medical library.

HAROLD L. MOFFAT, M.D.

Postoperative Care.

By H. J. B. Atkins, D.M., M.Ch., F.R.C.S., Fourth Edition, 338 pp., Price $6.75, Charles C. Thomas, 1952.

This is an ambitious undertaking by the chief surgeon of Guy's Hospital, London. He covers practically all fields of surgery, including fractures, excepting the ophthalmic area. It is most valuable when discussing general principles, such as clean and infected wounds, burns, and abdominal surgery. It deals specifically with such important items as tetanus, gas gangrene, and the antibiotics. There is an interesting chapter containing advice on court appearances, especially the avoidance of legal pitfalls. It is a good reference, though not a detailed one.

Generally, it is a very worthwhile volume.

ROBERT G. JOHNSTON, M.D.

Symptoms of Visceral Disease.

By Francis Marion Pottenger, A.M., M.D., LL.D., M.A.C.P., Seventh Edition, 446 pp., illustrated, Price $7.50, C. V. Mosby Company, 1953.

This book is divided into three parts: Part I—The Vegetative Nervous System; Part II—The Relationship Between the Vegetative Nervous System and the Symptoms of Visceral Disease; Part III—Innervation of Important Viscera with a Clinical Study of the More Important Viscerogenic Reflexes. This is the seventh edition of this work, which was first published in 1919.

Dr. Pottenger, who is a chest physician known for his exceptional skill in physical diagnosis, should be given credit for having long ago pointed out the importance of what today is called psychosomatic medicine. It is probable that this book has some historical value. Until such time as it is thoroughly revised and newer discoveries and newer terminology are incorporated into it, the busy physician would do better to look elsewhere. It is disconcerting, to say the least, to read statements about "recent articles" and "recent investigation" and find the references are to papers published in the early '20's. In the bibliography there are only two references to papers published in the last ten years and few to anything published in the last twenty years.

BROOKE GREANEY JAMIESON, M.D.

Retropubic Prostatectomy.

By Francis A. Beneventi, M.D., 227 pp., illustrated, Price $11.00, Charles C. Thomas, 1954.

This new monograph has a generous number of good photographs, some in excellent color plates and many taken from actual dissected specimens. The chapters on anatomy, especially the vascular anatomy, thoroughly clarify retropubic prostatectomy. Pre- and postoperative management are discussed in detail. There are many original drawings by Wm. P. Didusch. A summary at the end of each chapter together with bibliography enhances the value of the book. Unique is an evaluation of 100 cases in which "it will be seen that the postoperative convalescence is almost unbelievably good."

EDMUND ING, M.D.

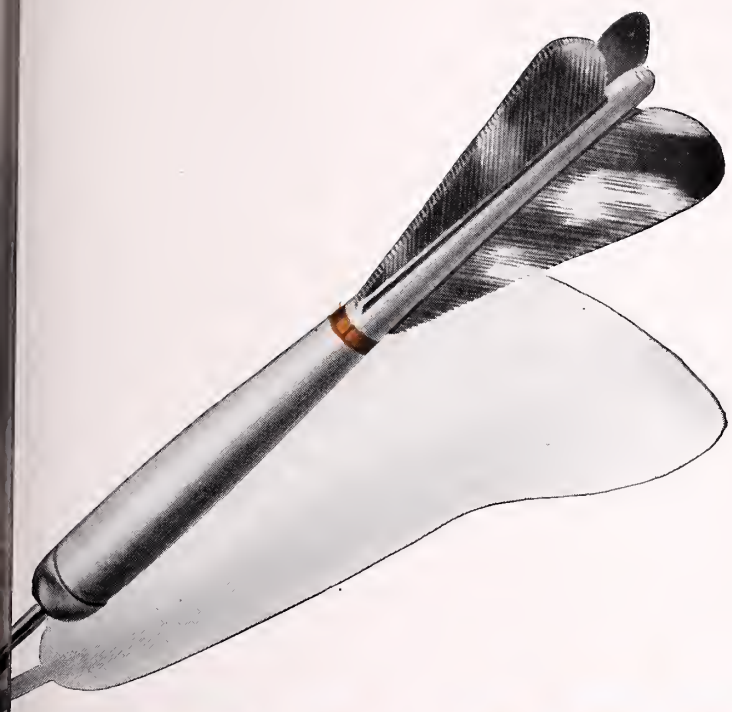
Emotions and Bodily Changes.

By Flanders Dunbar, M.D., Fourth Edition, 1192 pp., Price $15.00, Columbia University Press, 1954.

This is a valuable and almost exhaustive review of world literature on the production of bodily changes by emotion, with over 5,000 references, 751 pages of text and 175 pages of index. It is conveniently organized by body systems. The paper is good, the type is large and clear, and the style is concise and readable. There are numerous case reports. The portion on therapeutic considerations has been completely rewritten since the third (1946) edition. It is an invaluable reference work.

HARRY L. ARNOLD, JR., M.D.


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A History of Medicine—Volumes I and II.

By Ralph H. Major, M.D., 1155 pp., illustrated, Price $14.50, Charles C. Thomas, 1954.

Undaunted by the existing long list of fine books on the history of medicine, the author, famed for his "Classic Descriptions of Disease," has produced yet another—an excellent one—designed primarily for "the medical student and the medical practitioner." Reading this well-written, fascinating "account of the stream of medical history" has been a thoroughly enjoyable and stimulating experience, as it should be to every medical man, be he student or practitioner (or both).

Practitioners too "busy" to be students of their heritage will do well to reflect on the seemingly strange fact that so many of our outstanding medical historians have also been great clinicians. Doctor Major follows this Janus-faced tradition in the footsteps of Sudhoff, Albutt, Rolleston, Osler, Cushing, Fulton and Clendening.

It is no mean undertaking to depict the entire history of the healing arts from pre-historic man to the present day in a smoothly flowing narrative, supplying concise general-historical settings for each cultural period, and taking care not to distract the reader by scholarly minutiae. Doctor Major has achieved his aim so skillfully that the reader, never smelling the scholar's lamp, moves eagerly on from one exciting and thought-provoking page to the next. A chronological list of names, dates and events, constituting the short "outline" type of medical history, is unworthy of the name and makes for very dull reading.

History, to have significance, must deal with the record of cultures, their evolution, progressive changes, cumulative and accelerated increases, and complexity. Only this broad perspective enables us to understand why there were advances, lags or regressions instead of constant progress from one period to the next in one civilization or another; why one civilization died, another aborted (Eskimo, Polynesian), or became petrified (China), and yet another progressed to an Atomic Age.

We see the role played by necessity or environment. We see the stagnation in anatomical knowledge for centuries after Galen because of the Church's ban on dissection. We can understand why the ancient Hindu surgeons attained such phenomenal skill in rhinoplasty—born from the necessity of repairing the mutilated noses and ears sustained by the populace as punishments in accordance with the "Code of Manu." We see the part played by wars and new weapons in the advancement of surgery. We understand the hygienic and sanitary basis for the Jewish proscriptions of diet and the dawning concepts of contagion as the result of the great epidemics of history. We can appreciate the reason for the long delay in the use of instrumentation and technical methods, as well as their phenomenal development and acceleration once scientific methods and experimentation blossomed during the Renaissance.

One must bow his head in humility upon reading the glorious pageant of history as it is revealed in a book such as this one and, too, upon realizing that our recent scientific medicine stems from knowledge communicated from the gigantic thinkers from the past, and not from any superiority of brain matter in recent generations, since man's biological evolution ceased at least a half million years ago.

The text of Dr. Major's splendid book is enhanced greatly by several hundred interesting and unusual illustrations. The biographical data appended to each chapter, and an excellent bibliography, are offered as an enticing lure to those whose appetites are whetted, whatever their particular interest or specialty. As might be expected, the publisher, Charles C. Thomas, has produced an exceptionally fine piece of bookmaking.

Every medical man should own this work and read it. It makes a fine gift from a grateful patient or the family or, if worse comes to worst, you can always buy it for a treat to yourself.

H. H. Walker, M.D.

Standard Values in Nutrition and Metabolism.

Edited by Errett C. Albritton, A.B., M.D., 380 pp., Price $6.50, W. B. Saunders Company, 1954.

This is a collection of charts and tables as stuffed with information as Fort Knox is with gold. There are tables of proximate composition, including one on tropical fruits. A table of digestibility and absorbability is followed by others showing the absorption, retention, and excretion of catiogens and aniogens, both foreign and those normally found in tissue.

The most recent information on chemical elements in nutrition including ingestion, absorption, function, and excretion is tabulated. Signs of deficiency and excess, as well as the functions, of vitamins are included.

Most of the knowledge of the chemical changes of metabolism is comparatively recent, found largely in journals, but it is collected here. The chemical changes of lipids, proteins, and carbohydrates are shown, as well as the pathways of metabolism and catabolism for amino acids, purines, pyrimidine nucleotides and nucleoproteins, carbohydrates, and lipids. There are tables showing the path of excretion of nitrogenous compounds, vitamins, and hormones, electrolytes and minor minerals. There is an extensive bibliography.

All of this adds up to a valuable source book of basic information.

Marjorie G. Abel, M.S.

An Atlas of Pelvic Operations.

By Langdon Parsons, M.D., and Howard Ulfelder, M.D., 231 pp., illustrated, Price $18.00, W. B. Saunders Company, 1953.

This fine volume is designed to "teach the technical details of pelvic surgical procedures by means of illustrations." To accomplish this, each procedure is illustrated step-by-step. A descriptive text accompanies each plate.

Every pelvic operation is not described. Instead, the authors have offered that procedure which has proven most satisfactory for any given situation. It is not the authors' purpose to advise the reader what operation to select.

There are three sections. The first deals with abdominal operations, the second with perineal and vaginal procedures, and the third with operations for malignant disease. Of the latter, they have only included the more standardized and less extensive operations. This is wise since ultra-radical procedures are not yet standardized.

In all, this is a very satisfactory volume and should be especially valuable to house officers in surgery, gynecology, and urology.

Grover H. Batten, M.D.

Hypoglycemia and the Hypoglycemic Syndrome.

By A. J. Kauvar, M.D., and Martin G. Goldner, M.D., 67 pp., Price $3.00, Charles C. Thomas, 1954.

This monograph treats the subject of hypoglycemia and its related syndrome with clarity and conciseness. About two hours of reading provides an interesting historical review, differential diagnosis, and management of this interesting subject.

If you missed Dr. Conn's lectures on hypoglycemia (last year) this will serve as a comparable presentation; to those who heard him this will be an excellent review.

An extensive bibliography is supplied to the physician who has more specific problems relative to the subject.

CHEW MUNG LUM, M.D.

Surgery of the Elbow.

By Frederick M. Smith, M.D., 340 pp., illustrated, Price $9.75, Charles C. Thomas, 1954.

This book presents information on the elbow that would be found only by looking in many different texts. Its purpose is to deal with the various conditions in the region of the elbow that are amenable to surgical treatment or to a combination of surgical plus physiotherapeutic measures. It seems to be written primarily for the medical student, resident and younger surgeon.

Therein lies its danger, as the surgical treatment is emphasized rather than the closed manipulative methods, and it is just the reverse that should be impressed on the student. Only the experienced surgeon should attempt open operations on the elbow.

It will be useful in the medical school and hospital for graduate teaching, as the bibliography and illustrations are excellent.

WILLIAM H. GULLEDGE, M.D.

Psychosurgery and the Self.

By Mary Frances Robinson, Ph.D., and Walter Freeman, M.D., Ph.D., F.A.C.P., 118 pp., Price $3.00, Grune & Stratton, Inc., 1954.

This small volume is a noteworthy contribution to the important neurological, psychiatric and psychological problem of the effects of psychosurgery, and is due to the collaboration of a competent psychologist with a famous neuro-psychiatrist. How necessary such studies are is illustrated by Dr. Freeman's statement: "Inadequate operation is useless; too extensive operation is ruinous." Thus the value of the surgical procedure would seem to be dependent on psychological enquiry.

After an excellent review of previous studies, the rest of the book is mainly devoted to the theory that lobotomy modifies the patient's sense of self-continuity, which obviously involves self reference. Carried to extremes this becomes anxiety and obsessional thinking, which are therapeutically affected by operation particularly in the orbital area. The tests of self-continuity which Robinson uses, though not standardized with normal subjects, clearly differentiate lobotomy patients from a control group. In the reviewer's opinion, the tests seem to be too specific, psychologically speaking, to throw much light on frontal lobe functions in general.

S. D. PORTEUS, D.Sc.

Hysterectomy.

By John C. Burch, M.D., and Horace T. Lavely, M.D., 94 pp., illustrated, Price $5.50, Charles C. Thomas, 1954.

This little book (94 pages) is one that can be read through at one sitting, and it should be by everyone doing pelvic surgery.

The authors' chief point is the importance of proper selection and evaluation, physically, physiologically and psychologically, of patients for pelvic surgery. They emphasize that a poorly selected case cannot be helped by a good operation (nor a well selected case by a bad one).

This work presents a good review of the indications for hysterectomy and the sequelae. As a bonus feature the illustrated descriptions of their routine hysterectomy and their modified radical operation are of great interest and value. A final chapter on intraoperational emergencies is worth the price of admission alone.

I repeat, — a *must* for pelvic surgeons!

T. ROBERT WHITE, M.D.

Proceedings of the Fourth International Congress of the International Society of Hematology.

Edited by F. Jimenez De Asua, William Dameshek, and Sol Haberman, 473 pp., illustrated, Price $10.00, Grune & Stratton, Inc., 1954.

The well-edited compilation of the papers presented during the Fourth International Congress of the International Society of Hematology (held in Mar del Plata, Argentina, in September 1952) has been divided into eight sections dealing with hematology in all its phases. They are published in their original language but are accompanied by translations in abstract form in both English and Spanish. This volume will be of interest only to students of hematology.

T. F. FUJIWARA, M.D.

Pediatric Diagnosis.

By Morris Green, M.D. and Julius B. Richmond, M.D., 436 pp., Price $10.00, W. B. Saunders Company, 1954.

This book adequately fulfills its stated purpose of "helping students and practitioners to increase their diagnostic skill through a systematic and integrated approach to patient study."

Practitioners confronted with pediatric problems would find in Section II a complete refresher course in the techniques and disclosures (normal and abnormal) of the physical examination of infants and children, including assessment of skeletal maturation and motor development. Section III is a good reference for the differential diagnoses to be considered when confronted with the usual signs and symptoms bringing pediatric patients to the physician's office. Section IV includes a broad discussion of the physician's responsibility for the supervision of the health of the young population and the special problems encountered in each age group. There are ample references.

This book uses a recent innovation of inserting current references in the portions of text to which they pertain, rather than at the end of the section or chapter.

With its virtually timeless subject matter, this book should find a long and useful life on the bookshelf of any physician who sees infants and children in his daily practice.

WILLIAM F. MOORE, JR., M.D.

Your Future and You.
Emotions and Physical Health.

Published by the Metropolitan Life Insurance Company, Your Future and You—17 pp.; Emotions and Physical Health—10 pp., 1954.

These pamphlets, which are available with no charge to official and voluntary health agencies, are small and concise, attractive, accurate and highly instructive dissertations aimed at patients—and the marksmanship seems excellent. They can be highly recommended.

Your Future and You is concerned with various aspects of planning for happy longevity with references to diet, physical health and mental health. Its theme is really preventive geriatrics.

Emotions and Physical Health is an explanation in simple and expressive terms of how and why repressed emotions cause physical disease. There is much in it to instruct the doctor as well as the patient. It can be highly recommended for distribution to almost anyone who can read.

HARRY L. ARNOLD, JR., M.D.

Surgical Treatment of Cancer of the Cervix.

Edited by Joe V. Meigs, M.D., 462 pp., illustrated, Price $12.00, Grune & Stratton, Inc., 1954.

This volume is the first modern exposition of the surgical approach to the treatment of carcinoma of the uterine cervix. There has been a renewed interest in this approach, stimulated by the work of J. V. Meigs and his publications. The book is edited by Dr. Meigs; the contributors are an impressive list of well known national and international authorities. The presently accepted techniques, as practiced by those authors, are completely presented. The illustrations are of unusually high quality, the paper and printing excellent.

It is not only an authoritative reference, but stimulating reading for any one interested in advancing the attack on this disorder. It can be most heartily recommended.

ROBERT G. HUNTER, M.D.

Hyperparathyroidism.

By B. Marden Black, M.D., 119 pp., illustrated, Price $3.75, Charles C. Thomas, 1953.

This little monograph—one of the American Lecture Series—is a well knit and complete presentation devoid of excessive detail.

After an introduction emphasizing the importance of hyperparathyroid-consciousness and an interesting historical account of the disease, the author devotes the remainder of the volume to pathology, clinical aspects, diagnosis, and treatment, all of which are well set forth.

The author has drawn heavily on the Mayo Clinic material—a total of 112 cases—plus data covering approximately an equal number of proven cases gathered from the literature, thus offering an excellent cross section of experience.

This contribution is most worthwhile and certainly fulfills the author's purpose to broaden interest in and understanding of hyperparathyroidism, a disease entity far commoner than realized.

GROVER H. BATTEN, M.D.

Hernia.

By Chester B. McVay, M.D., Ph.D., 40 pp., illustrated, Price $7.75, Charles C. Thomas, 1954.

This is an atlas the purpose of which is to present concisely the present methods of repair of the more common hernias. The principle is to convert the abnormal to normal anatomic architecture. All types of hernias are described, even very rare ones. Considerable space is used in describing the management of inguinal hernias, these being the commonest type. The inguinal hernia problem has been hopelessly confused in the past 50 years by an enormous number of special operations. The confusion is compounded when anatomy texts perpetrate such artifacts as the "conjoined tendon" and others. The author clears these things up and gives his ideas of a physiologic repair. This is a fine book, and will soon become a standard source book, and could be used as a teaching manual.

DEAN M. WALKER, M.D.

Diagnostic Laboratory Hematology.

By George E. Cartwright, M.D., 104 pp., illustrated, Price $3.00, Grune & Stratton, Inc., 1954.

This publication is a brief, well organized handbook especially valuable to students of laboratory technique and to doctors who wish to do a few simple tests in their own offices.

It offers many useful hints in technique and possible sources of error of procedures that require a certain amount of skill.

Another very appealing feature is its frank evaluation of various tests such as the compared accuracy of the red blood count, hemoglobin determination and packed cell volume in determining anemia, etc.

A very convenient book to have around!

DOROTHY MATSUO, B.S.

Cancer—Diagnosis, Treatment and Prognosis.

By Lauren V. Ackerman, M.D., and Juan A. del Regato, M.D., Second Edition, 1,201 pp., illustrated, Price $22.50, C. V. Mosby Company, 1954.

The second edition of this scholarly work is most welcome since progress in the neoplastic field is constant and the first edition is seven years old.

The authors wisely have continued the book's dual partitioning. Part one includes sections pertaining to the general cancer problem—a survey of over-all cancer incidence, a resume of cancer research, the problem from the pathologist's point of view, and finally sections on surgery and radiotherapy. This part should be read by all doctors coming in contact with patients, for only then can the broad problem of cancer therapy—an entity separate and distinct from other medical problems—be fully appreciated. Clear emphasis of the need for the complete cooperation of a team consisting of surgeon, pathologist, and radiologist is set forth in this section.

Part two adheres to the original plan: diseases of the various systems are discussed relative to their anatomical considerations including an outline of their lymphatic pathways, incidence and etiology, pathology and natural history, diagnosis, and treatment. Every effort to reflect modern trends has been made. The authors—a pathologist and a radiologist—have presented the material on therapy with a surprising lack of prejudice toward any one modality.

(*Continued on page 356*)

HMSA—Its Place in the Community

Community Group Medical Plan

J. R. VELTMANN, *General Manager*

During the past eighteen months, health protection has become a subject of national importance. In labor-management negotiations, it has become a bargaining issue as a fringe benefit for a large portion of the nation's employed people. Two House resolutions were introduced in the 83rd Congress through the sponsorship of the Department of Health, Education and Welfare which called for government subsidies to develop this field of endeavor further. Certain closed panel group practices have also developed in various areas across the nation.

In view of this trend, the medical profession in Hawaii again took the initiative to develop a comprehensive Community Group Medical Plan. This plan may well indicate to the entire nation that a good, sound medical plan can be developed by the doctors on a free choice of physician and hospital basis and prevent the necessity of Federal Government intervention or the encroachment of closed panel type of medical plan. The action of the local medical profession is reminiscent of the farsighted action taken back in the early 1930s when the Territory needed a device by which the public could prepay medical protection. In 1938, the local doctors endorsed and sponsored the Hawaii Medical Service Association, Blue Shield Plan for Hawaii, as a non-profit health plan offering prepaid medical protection to the people of Hawaii. HMSA is possibly the first plan to offer home and office visits in addition to surgery and hospitalized illnesses. It also undertook the problem of protection against the high cost of hospitalization and is providing a service normally provided by Blue Cross Plans on the mainland. The doctors' confidence in HMSA has been fulfilled by the growth of the plan which began with less than 1,000 individuals in 1938 to over 87,000 members, which represents approximately 18% of the total population in Hawaii.

Development of a comprehensive community plan had been under study by the medical profession and HMSA for over one year and in the spring of 1954, the President of the Hawaii Medical Association appointed a special study group, "The Professional Services Committee," which spent several months reviewing and analyzing all phases of medical plan benefits.

The new Community Group Medical Plan, as approved by all County Medical Societies in Hawaii, preserves "free choice of physician and hospital," offers equal benefits to the employee, his wife and his children. Surgical allowances of the plan will be accepted as PAYMENT IN FULL by local surgeons for members whose annual income for the 12 months' period preceding surgery did not exceed $7,500 for an individual and $10,000 for the family. With this income clause as a part of the plan, approximately 97% of the membership would have their surgery paid in full by the plan.

Home, office and hospital visits for medical conditions or illnesses would be covered from the first visit and for a total of $300.00 for each separate illness or injury. Necessary x-ray and laboratory services for diagnostic purposes will be covered on a co-insurance basis, with the plan paying 50% and the member paying 50% of the scheduled charges. In answer to the demand for preventive care, the medical profession has agreed to "special" rates for annual physical examinations and immunizations shots for HMSA members, although such services are not a part of the benefits of the plan.

Liberal allowances are made for maternity care and tonsillectomy-adenoidectomy cases, to include both physician and hospital services. The subscriber is provided coverage for mental or emotional disorders up to a total of $200.00 for physician and hospital services.

Hospital benefits include payment in full of charges for operating room, anesthesia, drugs, antibiotics, special drugs, admission laboratory services, oxygen and radium rental and room and board charges at ward rates for a total of 120 days for each illness or injury.

The monthly premiums necessary to offer all the benefits specified were actually higher than the general public could afford to pay for medical protection; however, this was thoroughly analyzed by the medical profession and it was agreed that the doctors would underwrite their services in order that the plan may be priced within the reach of the man-on-the-street. It is the intent of the local physicians to make this plan available to as many individuals in the community as possible to prevent the necessity of development of any "closed panel" system or introduction of any Federal subsidized program for Hawaii.

A unique feature of this plan is the agreement by physicians to establish maximum charges for all classes of medical services as an additional protection to members of the plan. It will help to prevent any complaints about physicians using the medical plan as a plateau upon which high fees are built.

It is recognized that the success of the new Community Group Medical Plan depends principally on co-operation of all members, doctors, hospitals and efficient administration of the plan. The four major considerations are:

1. Educate members to the value of their medical protection to prevent unnecessary use of plan benefits.
2. Prevent overuse of diagnostic laboratory and x-ray services.
3. A special Governing Body of the Medical Society to establish censorsbip measures for dealing with the possible few cases of abuse of plan benefits by its members.
4. Sustained efforts by the hospitals to maintain hospital costs at the present level.

The doctors firmly believe that this low cost comprehensive medical plan is sound and affords the most practical means of providing the public with a necessary community service which will develop Hawaii as one of the healthiest communities in the nation.

Hawaii Medical Association

House of Delegates Meetings

At the call of the president, a special meeting of the Delegates was held in the Mabel Smyth Auditorium at 10 a.m. on Sunday, January 23, 1955. Dr. N. P. Larsen presided and the following delegates were present: Drs. Fronk, Durant, Kutsunai (Hawaii), S. L. Yee, Richert, J. L. Bell, Devereux, H. M. Johnson, Lowrey, R. G. Benson, Gilbert, E. Ing, L. Q. Pang, Quisenberry, Allison, Morgan, Paskowitz, Berk, C. Johnsen, Sexton, Wilkinson, S. Yamauchi, Cockett (Kauai), T. D. Woo (Hawaii), Hayashi (Hawaii), Tompkins (Maui); also Drs. West, Giles, Izumi and Spencer.

Dr. Larsen said Mr. Kaiser had stated that he would not introduce his health plan in Hawaii unless the doctors asked him to come in. Since there have been many reports that Kaiser was about to set up clinics here, the delegates were called to discuss the situation.

Following some questions and comments, Dr. Larsen read a draft of a proposed letter to Mr. Kaiser. It was moved and seconded that this letter be sent as written to Mr. Kaiser stating the views of the House of Delegates of the Hawaii Medical Association, and that a copy be sent to the newspapers. There was some discussion of the details of the Kaiser plan compared to the new HMSA plan, after which an amendment to the motion was proposed to the effect that the letter include an invitation to Mr. Kaiser to meet with the delegates.

Dr. Yee said he understood many doctors here had been asked to join Kaiser. Dr. Yee felt we must keep our doctors together and keep them satisfied in order to keep other plans out. He felt there were three inequities which should be corrected: (1) Many doctors feel there has been improvement in the handling of industrial medicine, but the doctors are wholeheartedly for free choice of physician in industrial accident cases, and somehow this should be accomplished. (2) Pre-employment examinations of employees by large groups of doctors tend to wean patients from their own doctors. (3) It is now time to consider abolishing the plantation medicine system if we feel that panel medicine is objectionable.

Dr. Larsen and Dr. Fronk replied that their groups referred patients to their own doctors for correction of defects found in pre-employment examinations.

Dr. Larsen also mentioned that plantation medicine was now open to consultants. Dr. Pang said plantation employees could only go to certain consultants except at their own expense. Dr. Larsen said he thought the plantations should write to all consultants to determine whether they will see industrial cases at industrial accident rates. However, Dr. Larsen also stated that if the Kaiser plan were introduced here, he felt it would split the profession far further than the inequities mentioned by Dr. Yee. He thought it would be wise to discuss such misunderstandings at another meeting.

After further discussion of the Kaiser plan and the letter, the amendment to include in the letter an invitation to Mr. Kaiser to meet with the Delegates was passed by a vote of 18 to 6.

The maker of the original motion to send the letter, retracted the words "as written" and the seconder agreed. The motion to send the letter to Mr. Kaiser stating views of the House of Delegates, with copies to the newspapers, was then passed by a vote of 17 to 2.

The Delegates proceeded to discuss the wording of the letter and various changes were agreed upon, including the invitation to Mr. Kaiser to meet with the Delegates. A final motion to make the sending of the letter unanimous was passed with 20 votes in favor and none opposed. The chairman announced that this made it unanimous. Following is the final form of the letter:

January 23. 1955

Mr. Henry J. Kaiser
4607 Kahala Avenue
Honolulu, Hawaii

My dear Mr. Kaiser:

We have noted from the newspapers that you have decided not to offer your method of sickness insurance to Hawaii unless there is a demand for it by the doctors. We realize your plan has brought needed medical and hospital service to many areas where such service was lacking. We can only commend you for such splendid service.

However, in Hawaii, we already have built more hospital beds than are needed. Also, during the past 17 years the doctors have gotten together and developed an insurance plan to spread the cost of sickness over a large number of people. To show the doctors' sincerity in developing this service, they were willing, during the formative years of their plan, to accept a withholding of ⅓ of all their charges.

A doctors committee has been working for a long time in developing a more comprehensive plan for the community, and you no doubt have read in the papers recently about this new plan. The medical profession as a whole is proud of their accomplishments and is doubly proud that such a plan will permit any doctor in the Territory the right to participate. This, we are satisfied, is the only fair approach.

We are now ready to start this plan. The doctors have voted overwhelmingly in favor of it and are willing to accept 80 cents on the dollar to get the plan working.

We, therefore, as delegates assembled and representing all the doctors of the Hawaiian Islands, wish to inform you that we appeal to your sense of fairness to not introduce a plan that has caused so much ill-will among doctors in the communities where it has been established. It is not needed here, and we do not believe it will improve medical service in Hawaii.

Those doctors who have told you they want you to come in are not speaking for the medical association and are a small minority.

We do admire the many great undertakings you have performed during your life. We do hope you will not push this endeavor which we feel certain will create a great deal of dissension within the profession and will not be in the best interest of our community.

As a house of delegates we would be happy to meet with you at a mutually agreeable time to discuss any phase of this important community matter.

Sincerely yours,
DELEGATES OF THE HAWAII MEDICAL ASSOCIATION

Dr. Larsen announced that he would appoint a committee to study the points mentioned by Dr. Yee.

A sheet of paper had been circulated for the signatures of the Delegates.

The meeting was adjourned at 12:10 p.m.

* * *

When Mr. Kaiser accepted the invitation to meet with the House of Delegates, a second special meeting was held in the Mabel Smyth Auditorium on Sunday, February 6, 1955, at 10 a.m. Dr. N. P. Larsen presided. The meeting was open to members of the Hawaii Medical Association and there were 66 persons present, including the following Delegates and alternates: Drs. Fronk, Durant, S. L. Yee, Richert, John Bell, Cushnie, Devereux, H. M. Johnson, Lowrey, R. G. Benson, Thomas Chang, Gilbert, Edmund Ing, Millard, L. Q. Pang, Quisenberry, Allison, Albert Ishii, Morgan, Pas-

kowitz, William Stevens, Carl Johnsen, H. M. Sexton, Wilkinson, and Shoyei Yamauchi of Honolulu; Drs. Hayashi and E. Wong of Hawaii; Dr. Cockett of Kauai; Drs. Tompkins and Fleming of Maui.

Mr. Henry Kaiser and his medical director, Dr. Sidney Garfield, spoke to the doctors and answered questions about various features of their medical prepayment plan. Dr. Garfield suggested that any or all members of the Medical Society might form themselves into groups for prepayment purposes. Such doctors might continue with their private practice in their own offices. They would also be paid for the care of patients who chose them under this plan. Dr. Garfield thought this plan as well as the HMSA community group plan could be made available so that patients might choose the type of coverage they preferred. Dr. Garfield said, "We think you are doing a good job and that you have a good plan. We believe this should be done by the doctors. Just add to your plan a group practice plan. If you don't do it, somebody else will. You will get lay control and third person control." He stressed that he thought such a plan should be worked out within the Medical Society.

After Mr. Kaiser and Dr. Garfield left the meeting, a motion was passed that a representative, inter-racial committee of group and individual practitioners be appointed to study the feasibility of the type of plan recommended by Dr. Garfield as a possibility within the boundaries of the Hawaii Medical Association. This committee shall recommend whether or not such a plan should be established in the Territory, by our Association or by a group outside our Association. Such study shall also consider the inclusion of preventive services. The committee was also authorized to call on anybody for discussion, without restriction. It will report its findings to the House of Delegates. This motion was passed with only 1 opposing vote.

Another motion was passed that any publicity concerning this meeting should come directly from an officer of this Association; also that a letter be sent to Mr. Kaiser and Dr. Garfield to thank them for meeting with the Delegates and to inform them of the positive action taken in the formation of a committee to study their proposals.

The meeting was adjourned at 12:25 p.m.

SAMUEL L. YEE, M.D.
Secretary

Umi Makahiki I Hala*

Postgraduate Course Concluded

Nearly five hundred medical officers of the Army, Navy and Public Health Service, and over a hundred and thirty civilian physicians, paid an estimated 2,775 visits to the fourteen sessions of the Postgraduate Course of the Honolulu County Medical Society, held January 8 to 14, 1945, in Honolulu. These sessions consisted of four symposiums, on cardiovascular disease, neuropsychiatry, cancer, and diseases of the chest, and ten round table discussions, on general medicine, eye, orthopedic and neural surgery, gynecology and obstetrics, urologic surgery, allergy, abdominal surgery, otology, tropical diseases and skin diseases.

Personals

It has recently been announced that **Cmdr. Paul Withington,** M.C., U.S.N.R., has been promoted to Captain. He is now stationed here at the navy dispensary of the old naval station.

Dr. T. Yoshina was recently appointed chief of staff of the Hilo Memorial Hospital. **Dr. Henry B. Yuen** and **Dr. Harold M. Sexton** will assist Dr. Yoshina as vice chief and secretary, respectively.

On January 11, 1945 a daughter, Nancy Lynne, was born to **Dr. and Mrs. Harold M. Johnson** of Honolulu.

Dr. Marvin Brennecke of Koloa, Kauai and **Dr. Rogers Lee Hill** of Honolulu were accepted into fellowship in the American College of Surgeons during 1944.

Dr. Walter M. Ozawa, Territorial Hospital, was promoted from associate member to full membership in the American Psychiatric Association at the meeting in Philadelphia in May, 1944.

Dr. Philip S. Arthur is the new assistant in the office of **Dr. Jesse W. Smith** in Honolulu.

* Ten years ago. From Volume 4, Number 4, March-April, 1945.

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County Society Reports

Honolulu

The regular monthly meeting of the Honolulu County Medical Society was held Tuesday, January 4, 1955 at 7:30 P.M. in the Mabel Smyth Auditorium. Dr. R. C. Durant presided and approximately 103 members and guests were present.

The minutes of the previous meeting were approved as read.

Five new members who were elected into regular membership at the last two Board of Governors meetings were given a warm welcome by the President and were received with hearty applause from the members. They were as follows: Drs. George Nip, Jun-Ch'uan Wang, Robert S. Spencer, Kimm-Chan Kenneth Lau and Edward Yamada.

The meeting was then turned over to Dr. Strode who introduced the Program on Trauma and served as moderator during the panel discussion. Dr. Warren White was called upon to address the audience, covering briefly the Program of Trauma that is being carried on here in the Islands. The scientific program, presented through the auspices of the American College of Surgeons, was as follows:

Present Day Emergency Treatment of Burns—DR. C. S. JUDD
Routine Tetanus and Gas Prophylaxis—DR. WILLIAM H. GULLEDGE
Emergency Treatment of Inhaled Foreign Bodies—DR. ALBERT HO
Traumatic Injuries of the Eye—DR. H. S. MOFFAT
The Acute Traumatic Belly—DR. ROBERT G. JOHNSTON

Following a short discussion the members adjourned to the lanai for refreshments.

* * *

A special membership meeting was convened Tuesday evening, January 11, 1955 in the Mabel Smyth Auditorium. Dr. R. C. Durant presided and approximately 144 members were present.

This meeting was called to discuss the new Community Medical Plan conceived by the Professional Services Committee and approved by HMSA and, after several changes, by the Board of Governors of the Honolulu County Medical Society.

It was requested by Dr. West that a discussion on a Major Expense Plan be included in tonight's discussion along with the Community Medical Plan. It was pointed out by the Chair that in accordance with the Constitution and By-Laws, only the subject for which the special meeting is called may be discussed and no other subject may appear on the agenda. Dr. West objected to the ruling of the chair and asked to have his objections recorded in the minutes.

A lengthy and heated discussion followed. Several questions, brought up for clarification, were answered as satisfactorily as possible by members who served on the committee which drafted the plan.

Excerpts from comments of various members were recorded in the minutes.

It was moved by Dr. Palma and seconded that the Community Medical Plan be approved as amended by the Board of Governors. After further discussion Dr. Nils P. Larsen moved that we delete from the motion the Board of Governors' recommendations and vote on the plan as originally submitted to the Board. Dr. Wyatt seconded the motion. Immediately following Dr. Dickson moved that the motion and the amendment be tabled and carried over to the next meeting, which was voted down. At the close of the discussion Dr. Larsen's amendment to the motion was put before the house for a vote. Twenty-five voted in favor and the majority opposed. The motion failed to carry. Dr. Palma's motion was put before the house for a vote. Eighty-three voted in favor and nineteen opposed. The motion carried.

There being no further business, the meeting adjourned to the lanai for refreshments.

* * *

The regular monthly meeting of the Honolulu County Medical Society was held Tuesday, February 1, 1955 at 7:30 P.M. in the Mabel Smyth Auditorium. Dr. R. C. Durant presided and approximately 105 members and guests were present.

The Program Committee presented a very interesting hour of reports by members of the Society which theoretically offered the doctors a tour of the world. They were as follows:

USA:	"Report on Advances in Medicine and Surgery at the University of Chicago" DR. R. B. CLOWARD
EUROPE:	"Report on Advances at the World Medical Congress, Rome 1954 and The Third International Congress of Chest Diseases, Barcelona" DR. L. C. BECK
CARIBBEAN:	"International Training of Health Workers in Puerto Rico" DR. RICHARD K. C. LEE
JAPAN:	"Radiation Sickness: Acute and Chronic" DR. K. EDGAR

The business for the evening included the approval of the minutes of the two previous meetings and approval of the annual budget for 1955-56 by members of the Society as submitted by the Board of Governors.

Drs. Thomas P. Frissell and George H. Mills were welcomed into the Society as new members. Dr. Y. C. Yang, Korean ambassador to the United States was given honorary membership upon recommendation of the Board of Governors.

A fitting tribute, written by Dr. Douglas Bell, was paid to the memory of Dr. Arthur Warren Duryea, a life member of the Society, and was read and unanimously accepted. A copy will be sent to his next of kin.

It was requested by Dr. Gaspar that Dr. Durant state his stand on Panel Medicine as he felt that The President as an elected head and representative of the Medical Society had made public utterances detrimental to the wishes of the majority of the membership. Thereupon Dr. Durant reiterated his pledge that he would work for the good of the majority and had made no entangling alliances and as long as he was President would make none. After some discussion a resolution was proposed by Dr. Ando. The whole matter was re-

ferred to the Medical Practice Committee for action and report back at the next membership meeting.

Mention was made by Dr. West that the ILWU Stevedore contract for medical insurance has been awarded the United States Life Insurance Company which submitted the same bid as that of HMSA. He also commented that the Hawaii County Medical Society has authorized HMSA medical committee to adjudicate all discrepancies on all their claims.

Special attention was called to *Today's Health,* the AMA magazine currently being publicized by the Woman's Auxiliary to the Honolulu County Medical Society to increase its circulation.

There being no further business, the meeting adjourned to the lanai for refreshments where the doctors were joined by their wives for a social hour.

* * *

A special meeting of the Honolulu County Medical Society was held on Tuesday, February 15, 1955 at 7:30 P.M. in the Mabel Smyth Auditorium. Dr. Durant presided and there were approximately 153 members present. The meeting was called to discuss "Contract Panel Medicine and Allied Subjects" at the request of Drs. Gaspar, A. Lee, H. C. Chang, J. Palma and T. H. Richert.

Dr. Gaspar initiated the discussion on the subject. He prefaced his remarks by assuming full responsibility for calling the meeting and apologized to the other members for having their names published as they were asked to sign his petition only as a formality to call this meeting. Dr. Gaspar spoke at length on panel medicine and its undesirable effects and implored the members of the Society to discuss the problem fully and come up with a strong recommendation against it. In closing, he introduced a motion concerning the views of the Honolulu County Medical Society on contract panel medicine. The motion was seconded by Dr. Palma.

Considerable discussion followed in which the members present expressed their opinions freely. It was suggested that the motion be referred to the Resolutions Committee for rewording. During the course of the discussion it was moved by Dr. Chung-Hoon and duly seconded that the motion on the floor be tabled indefinitely. After some parliamentary sparring, the motion was re-read by the chair. The motion to table was defeated by a majority vote.

An amendment to the original motion was suggested by Dr. J. M. Felix, to include in paragraphs (1), (2) and (4), "and injured," after the word "sick." The suggestion was duly seconded and passed with one dissenting vote.

The following motion, as originated by Dr. Gaspar and amended, was voted on and passed by a majority, with two dissenting votes:

It is the considered opinion of the members of the Honolulu County Medical Society that:

(1) In the treatment of the sick and injured, freedom of choice of physician with direct and immediate physician-patient relationship on a fee-for-service-basis is essential if the high standards and quality of medical care are to be preserved.

(2) Closed panel, prepaid medical care plans violate these principles and thereby endanger the current standards of medical practice. By closed panel, we mean a doctor or group of doctors who enter into a method of treatment of the sick and injured which eliminates freedom of choice of physician and fee for service.

(3) Any physician who participates as a member of a closed panel system in a prepaid medical care plan, whether he is on a salary or capitation basis, is not acting in a manner to accord with the letter or the spirit of the principles of medical ethics of the American Medical Association.

(4) The elected officers and the representatives on the Board of the HMSA and the delegates to the Hawaii Medical Association of the Honolulu County Medical Society should take due notice of this action of the members; that we disapprove of any negotiations that might be entered into leading to the acceptance of a closed panel method of the treatment and care of the sick and injured patient.

There being no further business, the meeting adjourned to the lanai for refreshments.

TORU NISHIGAYA, M.D.
Secretary

Kauai

The regular monthly meeting of the Kauai County Medical Society was held at the Wilcox Hospital on January 4, 1955 at 7:30 p.m. Members present were: Drs. Cockett, Fujii, Goodhue, Ishii, Kim, Kuhlman, Kuhns, Masunaga, Wade, Wallis and Boyden. Guests: Drs. Kemp and Schilling.

Mr. Veltmann of the HMSA reported on the current very satisfactory condition of HMSA and then discussed health insurance matters in general, pointing out many respects in which the HMSA is superior to mainland organizations. His talk was well received and there was considerable general discussion.

WEBSTER BOYDEN, M.D.
Secretary

The regular monthly meeting of the Kauai County Medical Society was called to order at 7:30 p.m. by Pres. Peter Kim, M.D., February 1, 1955, at the G. N. Wilcox Memorial Hospital Library. Members present were: Doctors Brennecke, Cockett, Fujii, Ishii, Kuhlman, Wade, and Wallis. Guests were Dr. Larsen, President of the Territorial Medical Society, and Mr. Joseph Veltmann, of the HMSA.

Dr. Kim then read correspondence from Dr. Connor in which she presented a plan of the Bureau of Crippled Children to have otological studies done on students of the 1st, 2nd, 5th and 7th grades, both public and Catholic schools. A motion was made by Dr. Wade and seconded by Dr. Fujii to approve this program.

Dr. Wade then made a motion which was seconded by Dr. Cockett to have a special meeting on March 11, 1955, for the purpose of having Dr. Lauren V. Ackerman speak to the County Medical Society.

The nominating committee then presented their nominees for office in the County Medical Society as follows: Pres., W. Boyden; Vice Pres., K. Kuhlman; Sec.-Treas., B. O. Wade.

Dr. Nils P. Larsen, President of the Territorial Medical Association, then gave the President's annual address to the Kauai County Medical Society. He showed a movie on the new treatments in hypertension. This was followed by a movie depicting a pageant that took place in the dedication ceremony of the new surgical wing at The Queen's Hospital, Honolulu. This interesting movie was followed by some slides of various unusual surgical and medical cases.

Mr. Joseph Veltmann of the HMSA then presented to the Kauai County Medical Society a brief discussion on the new community group medical plan of the HMSA. A motion was made by Dr. P. Cockett and seconded by Dr. K. Fujii to approve the new community medical plan as proposed by the professional committee of the HMSA with one modification: that the word maximum on the fee schedule should be changed to read maximum and unusual condition. Motion carried.

Dr. B. O. Wade then made a motion, seconded by Dr. S. R. Wallis, to authorize the HMSA medical com-

mittee to act as the adjudicating committee in questionable billing on claims submitted to HMSA by members of the Kauai County Medical Society. Motion carried.

KEITH KUHLMAN
Acting Secretary

Maui

The meeting of the Maui County Medical Society was held on Tuesday, December 14, 1954 at the Central Maui Memorial Hospital. Present were: Doctors Fleming, Izumi, Burden, Underwood, Kashiwa, Wong, Tompkins, Sanders, McArthur, Rockett and H. Kushi. Dr. Warshauer, guest.

A letter from Dr. Warren White stating that the Trauma Committee is available for programs on the outer islands was read. This was approved for the February meeting.

Dr. McArthur reported that Mr. Kennedy is willing to come here and discuss Honolulu's fee collection agency and the possibilities of what might be done on Maui in a similar way. Dr. McArthur moved that the Society pay the expenses of Mr. Kennedy to come to Maui to talk to the Medical Society at some future date. The motion was seconded by Dr. Fleming and carried unanimously.

The program consisted of a talk by Dr. Jacobson on Electroencephalography. He also initiated a discussion regarding the advisability of his coming to Maui periodically for neuropsychiatric clinics. The consensus was that such clinics should be highly desirable.

L. S. ROCKETT, M.D.
Secretary

The regular meeting of the Maui County Medical Society was held on Tuesday, January 18, 1955, at the Central Maui Memorial Hospital. Present were: Doctors Rockett, McArthur, Izumi, Kashiwa, Wong, Totherow, Tofukuji, Shimokawa, St. Sure, Sanders, Cole, Patterson, H. Kushi, Underwood, Burden, Fleming, Tompkins and Ferkany.

Dr. Larsen, President of the Hawaii Medical Association, was also present. He presented two movies: Treatment of Hypertension and the Pan-Pacific Medical Pageant. Dr. Larsen also gave a brief report on diagnostic studies and showed Kodachrome slides.

Mr. Veltmann of HMSA presented the latest report on the present HMSA medical plan as approved by the Honolulu County Medical Society. After much discussion, the Maui County Medical Society passed the plan as presented by the Committee appointed by the president of the Hawaii Medical Society. The wording "maximum payment" on the second column was changed to "specialist care and special situations."

HAROLD S. KUSHI, M.D.
President

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Notes and News

DOCTORS

Travel . . .

. . . from the Mainland

Dr. Francis Kin Lum returned from the mainland and resumed his practice of general surgery at 288 South Vineyard Street.

Dr. E. R. Austin, formerly of the Straub Clinic, also returned from a mainland trip and resumed practice at the King Kalakaua Building, 1409 Kalakaua Avenue.

Dr. Herbert Rothwell returned to Kahuku after a 2-month absence in Colorado.

Dr. Robert G. Hunter also returned from several weeks tour of the East coast. Dr. Hunter's trip was sponsored by the Worcester Foundation for Biologic Research. He spent two weeks at the Brookline Free Hospital at Worcester, Massachusetts, a week with Dr. Abraham Stone at the Margaret Sanger Hospital in New York, and a week attending the American Academy of Obstetrics and Gynecology meeting.

Dr. Ralph B. Cloward returned to the islands after serving for the past 6½ months as visiting professor and head of the Division of Neurological Surgery at the University of Chicago. While on the mainland, he addressed the Chicago Neurological Society on "Pathology and Mechanism of Pain in Ruptured Intervertebral Discs"; he also addressed the staff of the Massachusetts General Hospital and the New England Medical Center, in Boston, on the subject of "Vertebral Body Fusion for Ruptured Lumbar Discs." In New York City he spoke to the staff of the Neurological Institute on the same subject. During his stay at the University of Chicago, Dr. Cloward was elected to the Chicago Chapter of Sigma Xi, the national society for scientific research.

Dr. Angie Connor, physician with the Territorial Board of Health, returned from meetings of the American Academy of Pediatrics in Chicago, and the American Public Health Association in Buffalo, New York. Upon her return, she addressed the Hawaii Association to Help Retarded Children.

. . . from Washington, D.C., and Puerto Rico

Dr. Richard K. C. Lee, President of the Territorial Board of Health, attended the meeting of the State and Territorial Health Officers in Washington. At San Juan, Puerto Rico, he inspected the health education facilities provided by the Foreign Operations Administration.

. . . from Stockholm, Sweden

Dr. Linus Pauling, Jr., attended the ceremonies in conjunction with the presentation of a Nobel Prize in chemistry awarded to his father, Dr. Linus Pauling, Sr., who is affiliated with the Department of Chemistry of the California Institute of Technology.

. . . to Japan

The Japan Medical Association in cooperation with Hawaii Medical Association is sponsoring another Hawaii-Japan Medical convention tour in the spring of 1955. The tour is planned for 25 days and is to include the convention of the Japan Medical Association at Kyoto. The itinerary covers visits to Tokyo, Kamakura, Hakone, Atami, Nagoya, Futamiyagura, Nara, Kyoto, Osaka, Hiroshima, Miyajima, Nagasaki, Unzen, Kumamoto, Hakata, Fukuoka, and Nikko.

Congratulations on . . .

. . . new babies

Dr. and Mrs. Richard Moore announced the birth of a daughter, Anne Sheridan, their fifth child, born on January 4, 1955.

Dr. and Mrs. Mortan Berk are proud parents of a baby boy, their fourth child and third son, Clay Preston, born on January 12, 1955.

. . . engagement

Dr. Thomas S. Bennett and Miss Margaret (Muggy) Hind Clark announced their engagement on December 25, 1954.

. . . birthday

Dr. Fred M. K. Lam celebrated his 60th birthday on January 10, 1955. Dr. Lam was born in Honolulu, the eighth of 15 children. He attended St. Louis College, Creighton University in Omaha, and St. Louis University in St. Louis, Missouri. He served his internship at the St. Luke's Hospital, San Francisco, and Queen's Hospital, Honolulu. Dr. Lam always led and still is leading a full professional life. At one time, he was a Director of the Bureau of Communicable Diseases, and organized the Bureau of Infant Hygiene and Crippled Children Program of the Territorial Department of Health. He is serving his twelfth year as Regent of the University of Hawaii. He is Director of the Honolulu Chamber of Commerce's Asia and Pacific Council. He is on the Board of Directors of scores of medical and business organizations. In addition to his many duties, Dr. Lam finds time to raise orchids and travel to mainland and foreign medical conventions.

Into the Army . . .

Dr. Robert Browne, of the Psychiatry Service of Queen's Hospital, was called to active duty with the United States Army, with a rank of Captain, on December 27, 1954.

Dr. Bunzo Nakagawa, formerly surgical resident of Queen's Hospital, joined the Army as a First Lieutenant on December 27, 1954.

. . . and out

Dr. Gordon Y. H. Chang was discharged after two years in Korea and at Tripler Army Hospital as a First Lieutenant.

Shooting . . .

. . . pheasants

Dr. S. C. Culpepper reports good hunting at Kamuela during the latter part of December and January.

. . . 50,000 patients

Dr. Richard K. C. Lee announced that a joint drive sponsored by the Territorial Civil Defense Agency and the Territorial Department of Health resulted in the immunization of 50,000 people against tetanus.

Newly elected . . .

. . . presidents

Dr. Abraham Ng Kamsat has been elected President of the St. Johns University Alumni Association.

Dr. Philip Corboy has been elected President of the Hawaii Chapter of the Loyola Alumni Association.

Dr. Gail G. L. Li was installed as President of the Chinese Junior Chamber of Commerce.

Dr. L. Clagett Beck is the new President of the Hawaii Society of the Sons of the American Revolution.

Dr. H. L. Arnold, Sr., was re-elected President of the Leahi Hospital.

Dr. Lester Yee was elected President of the St. Francis Hospital Medical Staff.

. . . vice-presidents

Dr. Thomas Fujiwara was elected vice-president of the Hawaii Cancer Society.

Dr. Harry L. Arnold, Jr. was elected first vice-president of the Oahu Health Council.

. . . directors

The Hawaii Committee on Alcoholism elected **Dr. Nils P. Larsen** and **Dr. Hastings H. Walker** to its advisory board.

New Correspondent

Dr. William John Holmes was appointed correspondent from Hawaii to the *Journal of the American Medical Association.*

ARTHUR WARREN DURYEA, M.D.
1896 - 1955

Arthur Warren Duryea was born at Roxbury, Massachusetts, February 14, 1896 and died January 13, 1955 at Palm Springs, California. He went to Lawrenceville Preparatory School and spent one year at Brown University before serving in the U. S. Army in World War I. After the war he went to Dartmouth where he graduated in 1921, A.B., *cum laude*. He completed his medical education at Columbia University in 1923, and then interned at Bellevue Hospital. He became a specialist in internal medicine, and was a Diplomate of the American Board of Internal Medicine, a member of the American College of Chest Physicians and a Fellow of the American College of Physicians.

He came to Hawaii in 1925 to become resident physician at Samuel Mahelona Tuberculosis Hospital for two years. Prior to his arrival in Hawaii he had had intensive work in tuberculosis at Bellevue and at Trudeau, where he was a resident student. His intimate contacts with the disease gave him a great insight into the problems of tuberculosis. He initiated, in the Territory, ambulant treatment. Very early in his career he gave collapse therapy in his office. His warm, jovial personality and his great personal interest in patients' problems endeared him to a large clientele. In his training he had inclined to specialize in surgery, but his own illness with tuberculosis altered this leaning. In 1927 he was made head of the Tuberculosis Bureau of the Territorial Board of Health.

Art was a complex personality—so able in many fields. He had won Phi Beta Kappa at Dartmouth without appreciable effort. He was a splendid organizer and, if inclined, would complete difficult tasks quickly. To the Honolulu County Medical Society he gave much. Our library really began in 1933 when he took over this responsibility. It was removed from the room in Queen's Hospital where Dr. Price now has his office to an unfinished room at the end of Liholiho III. A dual purpose Secretary and Librarian, Miss Watson, was employed, and our library started. He likewise had much to do with the earliest plans for the Mabel Smyth Building. He loved arguments and thrilled and thrived on pulling upsets at our annual elections. He preferred being the King-maker rather than the King.

He had a great and varied interest in community affairs, as evidenced by his work at Palama Settlement, on the Territorial Boxing Commission, and as a member of the Territorial Board of Medical Examiners. He with a few others gave the first mass immunizations against diphtheria, pertussis and tetanus in Honolulu. He left the Territory in 1947 and became affiliated with the Veteran's Administration in Louisiana as a specialist in internal medicine.

Although in his everyday life he apparently enjoyed being a controversial figure, he fought hard for his convictions and his friends. He will be greatly missed. To his immediate family are extended the condolences of the Society. Aloha, Art.

DOUGLAS B. BELL, M.D.

What is Ahead for the Far East?

was the subject of a talk given by Korean Ambassador **Dr. Y. C. Yang** to the faculty and students of Santa Barbara College and townspeople at Santa Barbara, California. Dr. Yang voiced the hope that the Western nations will unite in a Far Eastern policy.

In the Scientific Corner

The December issue of *Postgraduate Medicine* contains 16 articles and 2 editorials from staff members of the **Straub Clinic.** This journal is the official organ of the Interstate Post-Graduate Medical Association and is aimed principally at general practitioners across the country.

Reprints are on hand of talks given by **Dr. Richard D. Kepner,** during his trip to the Far East in the summer of 1953. "Psychiatry for the Physician" was published in the *Medical Review of Reviews* at Delhi, India, and "Some Aspects of Psychiatry for the Non-Psychiatrists" appeared in the *Journal of the Medical Association of Thailand.*

Hawaii Sets the Example

Dr. Frank C. Spencer, Cytology Committee Chairman of the Hawaii Cancer Society, announced that Seattle will soon have a cytology laboratory similar to the one in Honolulu. The local laboratory is believed to be the only one in the world which offers free service to all physicians.

Decoration

Lieutenant Colonel John F. Kellogg, Jr., surgeon with the 25th Infantry Division at Schofield Barracks, received the Legion of Merit recently. The presentation was made by Major General Herbert B. Powell, division commander, for "exceptionally meritorious conduct in the performance of outstanding service as commanding officer, 11th Evacuation Hospital, in Korea" in 1953-54.

Address

Dr. Edgar S. Childs spoke before the Hawaii Academy of General Practice on the subject of isotopes and their value to future practice in Hawaii.

Joined the Straub Clinic

Dr. William A. Gulledge is now with the orthopedic department of the Straub Clinic. Dr. Gulledge is a graduate of Cornell University School of Medicine. He interned at New York Hospital. Following his internship, he spent 13 years as medical officer with the United States Navy. He received his orthopedic training at the United States Naval Hospital in Philadelphia and the Shriners' Hospital in Honolulu. He is certified by the American Board of Orthopedic Surgery and is a member of the American Academy of Orthopedic Surgery. Dr. Gulledge is married and has three children.

Island News . . .

. . . from Hawaii

Dr. Chisato Hayashi of Kealakekua must have been trying for a record when he delivered four sets of twins in three weeks recently at Kona Hospital.

. . . from Kauai

Dr. and Mrs. Eichi Masunaga welcomed their first child, a boy, on January 26.

Dr. and Mrs. Peter Kim added a baby girl to their family on January 3. She is their second child.

NEWS

Student American Medical Association

Representatives from 67 medical schools in the U.S. will attend the Fifth Annual Convention of the Student American Medical Association at the Sherman Hotel, Chicago, Illinois, May 6, 7, and 8.

A highlight of the three-day meeting, which includes the official deliberations of the sixty-seven-member House of Delegates, will be the First Annual Banquet, held May 7. **Dr. You Chan Yang,** Korean ambassador to the U.S., will speak on "Medicine and Diplomacy."

All members of the medical profession who are in the Chicago vicinity during the convention are invited to attend the meeting.

American Goiter Association

The 1955 meeting of the American Goiter Association will be held in the Skirvin Hotel, Oklahoma City, Oklahoma, April 28, 29 and 30, 1955. The program for the three-day meeting will consist of papers and discussions dealing with the physiology and diseases of the thyroid gland.

ENT Assembly

The Department of Otolaryngology, University of Illinois College of Medicine, announces its Annual Assembly in Otolaryngology from September 19 through October 1, 1955. This Assembly will consist of two parts.

Part I. September 19 through September 24, 1955, will be devoted to surgical anatomy of the head and neck, fundamental principles of neck surgery and histopathology of the ear, nose and throat. This week will be under the personal direction of Maurice F. Snitman, M.D.

Part II. September 26 through October 1, 1955, will be devoted entirely to lectures and panel discussion of advancements in otolaryngology. The chairman of this section will be Emanuel M. Skolnik, M.D.

Registration is optional for one or both weeks.

Allergists Hold Annual Meeting

The Eleventh Annual Congress and Graduate Instructional Course in Allergy of The American College of Allergists will be held at the Morrison Hotel in Chicago, Illinois, April 25 through the 30th.

Further details and the program may be obtained by writing American College of Allergists, La Salle Medical Building, Minneapolis 2, Minnesota.

Physician Pilots

Some time ago several physicians simultaneously conceived the idea of forming a national society of flying physicians. Initial action was started by Mr. Mark E. DeGroff of Tulsa, Oklahoma, medical equipment manufacturer, who offered to act as a central office until preliminary arrangements could be made. A notice in the A.O.P.A. Newsletter brought forth

over one hundred interested inquiries. About twenty-eight physician pilots attended the American College of Surgeons Meeting in Atlantic City and twenty four attended the AMA session in Miami. It was felt that enough interest was shown to warrant an attempt to organize.

It was decided that the purposes of this society should be scientific, educational, and social. Physicians have a considerable influence which should be passed on to everyone to promote greater aviation safety. Further, physicians who have this interest could learn much about the technical aspects of flying from association with each other.

The immediate objectives are: compilation of a complete list of physician pilots; appointment of temporary local area chairmen; the collection of ideas and suggestions; and encourage physicians to fly in to the AMA Meeting at Atlantic City, June 6-10, 1955.

A scientific and social program can be arranged at Atlantic City if enough interest is shown.

Will physician pilots who are interested please send their names, plane flown and landing field to the local chairman of their area, or, if not known, to H. D. Vickers, M.D., 25 Jackson Street, Little Falls, New York, temporary chairman.

Doctor Needed

The Marine Corps Reserve is in great need of a doctor to do physical examinations in Honolulu. Not more than two hours a week. No drill. Must be a doctor holding commission in Army, Navy or Air Corps Reserve. Pay in accordance with rank. Please get in touch with Dr. William Walsh or Mr. Louis Blissard (Federal Attorney's office).

Correction

In an open letter to Senator Eva K. Bowring from Dr. Richard K. C. Lee about the Hansen's disease program in Hawaii, published in the January-February 1955 issue of this Journal, there was a typographical error. The number of acres of land at Waimano, the site of Hale Mohalu, is 11.223, and not 11,223.

— EDITOR

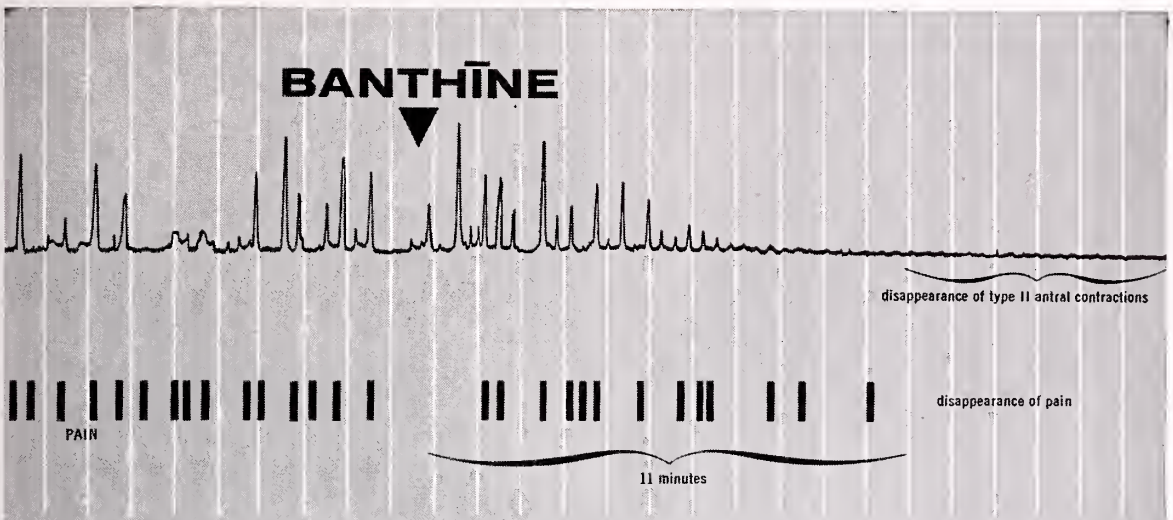
Physical Medicine and Rehabilitation

The 33rd annual scientific and clinical session of the American Congress of Physical Medicine and Rehabilitation will be held August 28–September 2, 1955 inclusive, at the Hotel Statler, Detroit.

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Effect of 100 mg. of Banthine administered orally on antral gastric motility and duodenal ulcer pain.

Hightower, N. C., Jr., and Gambill, E. E.: Gastroenterology 23:244 (Feb.) 1953.

Hypermotility and Hyperacidity

A recent evaluation of anticholinergic therapy in peptic ulcer emphasizes the fact that now the profession has at its disposal agents that are "effective in reducing both secretory and motor activity of the stomach."

The effect on motor activity is generally more pronounced and less variable than on secretion; pain relief is usually prompt; a high degree of effectiveness is noted in ambulatory ulcer patients.

Ruffin, J. M.; Texter, E. C., Jr.; Carter, D. D., and Baylin, G. J.: J.A.M.A. 153:1159 (Nov. 28) 1953.

With its proved anticholinergic effectiveness, Banthine has been found extremely useful in the medical management of active peptic ulcer, whether duodenal, gastric or marginal.

The immediate increase in subjective well-being and the simplicity of the Banthine regimen assures patient cooperation. The recommended initial therapeutic dose is 50 or 100 mg. (one or two tablets) every six hours around the clock, with subsequent individual adjustment. The usual measures of diet regulation, rest and relaxation should be followed.

Banthine is effective in other conditions caused by excess parasympathetic stimulation. These include hypertrophic gastritis, acute and chronic pancreatitis, biliary dyskinesia and hyperhidrosis. Banthine is contraindicated in the presence of glaucoma and should be used with caution in the presence of severe cardiac disease or prostatic hypertrophy.

Banthine bromide (brand of methantheline bromide) is supplied in scored tablets of 50 mg. and in ampuls of 50 mg. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

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INTER-ISLAND NURSES' BULLETIN

Official Publication of the Nurses' Association, Territory of Hawaii

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PRESIDENT'S MESSAGE

The American Nurses' Association held an Advisory Council meeting in New York City on January 25 and 26 which your president was privileged to attend. Discussion centered around organizational structure, economic security and public relations.

It was brought out that while the new structure is functioning efficiently on a national level, serious difficulty is being experienced by state and district organizations. Many representatives to the Advisory Council stated that a sense of frustration and considerable confusion were evident in attempts made to bring the national pattern down to state and district levels. Often expressed problems were the dearth of individuals able and willing to accept appointments, ineffective meetings, and the lack of adequate funds. It was felt that perhaps having one national nursing organization instead of two might solve many problems. However, it seemed to be the general opinion that a longer period of trial of the current structure would be necessary before it would be possible to decide intelligently what would be the better plan. A sociologist advised strongly against making another change at this early date; one of the members of the Advisory Board said that we would demonstrate our need for a psychiatrist if we made a second revision at this time. One of the reasons for the acceptance of the two organizational structures a few years ago was that we wanted a nursing organization to which non-nursing members could belong with full voting privileges. There is reason to believe that many of the present non-nurse members of the National League for Nursing would prefer to contribute to the advancement of nursing on a non-voting but also on a non-due-paying basis. This has already been shown to be true in some areas. It is recommended that all state leagues for nursing sound out the feelings of their non-nurse members on this issue. It is further recommended that state nurses' associations send in to National Headquarters written suggestions for improving the pattern of organization of the American Nurses' Association. Personnel at National Headquarters admit very frankly that they do not have the answers to all questions on structure and they welcome ideas from constituent associations.

Points brought out regarding section organization that seemed to be of special interest were:

1. EACT and INSA sections are combined in Connecticut although there is a total membership four times as great in Connecticut as in Hawaii.
2. In some states, the special groups sections in districts which have small memberships include public health nurses, industrial nurses and other occupational groups for which individual sections have been provided on state and national levels. In this way, voting privileges for delegates on a district level are safeguarded. However, this pattern presents other problems.
3. There is only one functions, standards, and qualifications committee for each section, although there are as many minimum employment conditions committees as there are subunits.
4. District sections should be organized when the need for them is expressed.
5. In one state section chairmen form a co-ordinating committee and at each board of directors meeting of SNA (state nurses' association), one chairman gives a joint report for all sections.
6. Pennsylvania State Nurses' Association allows all sections a set amount for routine expenses such as transportation and then an additional

twenty cents per member of each section. The board of directors must be petitioned if additional funds are needed. The per capita provision seems to be an incentive for increasing membership. However, it was suggested that actual membership compared with potential membership might be an even more stimulating basis for section budget determination.

7. Cross-sectional conference groups may be formed to advance clinical interests. This is the structure recommended for the operating room nurses. It was stated that the Arkansas Study on Operation Room Nursing should be very valuable to nurses working in this area.
8. Real interest in ANA work comes through participation in association projects. It was felt that the present organization of sections according to occupational groups has done much to stimulate interest in ANA and to increase membership.

In the area of public relations, it was emphasized that a program along these lines should begin with a determination of the needs. The impressions made by individual nurses are important in forming favorable public opinion. Workshops on public relations should be encouraged. ANA has one committee on public relations, convention program, and membership since these three areas are so closely related. In some states newly licensed graduates are given courtesy membership in the SNA for the balance of the current year. In one state a "Miss Student Nurse of 1955" contest as a public relations venture is underway. Perhaps such a contest, or a contest for the "Miss Bedside Nurse of 1955" would be very worthwhile in Hawaii.

Several points regarding legislation were discussed briefly. It was emphasized that membership on boards for the licensing of nurses should include only professional nurses. The possible trend toward a central licensing bureau in our state government was given some consideration. While a central licensing law would probably effect some economy and therefore should be given careful consideration, every effort should be made to include in such a law provisions to protect the autonomy of the profession regarding the licensure of nurses and to safeguard nursing control over funds contributed to the licensing board by nurses.

It was brought out that an economic security program need not be costly. How the Washington State Nurses' Association financed its program is described in the January issue of the *American Journal of Nursing*.

The National Student Nurses' Association structure was discussed at some length. SNAs were encouraged to urge students to pay their dues on an individual basis promptly.

Miss Annabelle Petersen urged SNAs and SLNs (state leagues for nursing) to cooperate on the matter of getting nursing prepared for national defense. She described two booklets published by the National League for Nursing which are meant to help schools of nursing provide their students with the knowledge necessary for nursing in national defense. She also emphasized the importance of enrolling for the course in atomic nursing being currently offered. She felt that the state committee on Nursing in National Defense has a very important piece of work to do at this time.

The time spent at the meetings of the Advisory Council passed very quickly. A great deal of ground was covered and many issues were clarified. It was very helpful to see our national "experts" face-to-face and to be able to talk to them about problems in Hawaii. Your president is very grateful for the opportunity.

SISTER MARY ALBERT, R.N., O.S.F.

CULTURAL BELIEFS AND PRACTICES OF THE CHILDBEARING PERIOD AND THEIR IMPLICATIONS FOR NURSING PRACTICE*

(AMONG CHINESE, FILIPINO, HAWAIIAN AND JAPANESE FAMILIES LIVING IN HAWAII — 1953)

Hawaiian Beliefs and Practices

The Hawaiians, a branch of the Polynesian race, are believed as a result of careful scientific study and investigation to have migrated from a center of culture in the Society Islands. The date of arrival from this southerly source is obscure; however, it has been estimated that people were settled in the islands by 1150 A.D. Radio carbon determination from charcoal ash rather definitely sets the date of habitation at 1004 A.D. with a range of error 180 years one way or the other—1184 to 824. Further deduction is that people had been living in the area several hundred years prior to these dates.

The first point of contact in terms of outside cultural influences occurred when Captain Cook came upon the Hawaiian Islands in 1778, although there is speculation that there may have been earlier inroads, probably Spanish. The English discovery was a matter of fortuity, not conquest or possession, however an expedient discovery since the islands were favorably situated in relation to trade lanes from the Western World to the Orient. The islands developed subsequently as an area of trade for English sailing vessels as well as ships from other countries, as an important source for exchange of supplies.

Although the primary premise of this social interchange was trade, there were unintended consequences on the native population and culture

* By the Staff of the Bureau of Public Health Nursing, Territorial Department of Health.

as a result. With the arrival of the first group of missionaries from New England in 1820, new influences were imposed on the people. A direct frontal assault was made on native culture and values, the aim here being conversion from a pagan religion and way of life to a Christian one.

Then with the development of agriculture, peoples from Eastern areas were imported for plantation labor, creating another point of contact in terms of social and cultural influences.

Thus it is readily seen that in terms of cultural transition a very different set of circumstances existed for the Hawaiian as opposed to the other racial groups in this study—Chinese, Japanese, or Filipino. Members of these groups voluntarily sought and accepted change while the Hawaiian had new influences imposed upon him. Exposure to change has been longer, and at various levels of contact—trade, assault on highly systematized set of religious beliefs closely interwoven with superstition and custom, other racial groups, etc. These circumstances give rise to a number of speculations in terms of rate and nature of transition, the sloughing off of the old and assimilation of new under the impact of varied cultural influences, and in this specific instance in relation to patterns associated with childbearing.

Material in relation to cultural patterns and beliefs associated with the childbearing period obtained from older Hawaiian women, as a basis to study data collected in subsequent interviews with younger women of reproductive age, unfortunately is rather limited. There was apparently some reluctance, on the part of women who might know some particularly well informed oldster as a possible source, to refer her to members of the study group; and similarly a reluctance on the part of the older women interviewed, to participate

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Since a large proportion of the public health program in Hawaii is concerned with maternal health education, the public health nursing staff decided to sharpen its perception of the cultural beliefs and practices about childbearing which persist today, on a conscious level, among families of Hawaiian, Filipino, Chinese and Japanese origin. This paper is a report of the findings of this investigation conducted in Hawaii's inter-racial human laboratory and of the implications of these findings to nursing practice.

A review of the literature disclosed a dearth of information on the subject and so the first phase of the project was directed toward obtaining as much information and understanding as possible of the early Hawaiian and "old country" beliefs of the Chinese, Filipino and Japanese. This material was gleaned through intensive interviewing of several elderly women of each ethnic group, who had had childbearing experience here in the case of the Hawaiian, and in the old country in the case of the other groups. The material derived from these interviews is used as a basis to compare the cultural practices which have been found in second and third generation families of these ethnic groups who have borne children in Hawaii.

In the next phase of the project, the nurses interviewed Chinese, Filipino, Hawaiian and Japanese families who satisfied these selection criteria: (1) in its cultural identification the family considered itself to be dominantly Hawaiian or Filipino or Chinese or Japanese. Ethnic mixture of itself did not exclude the family from selection since this criterion had to do with how the family regarded itself as a "cultural island"; (2) in the case of the Chinese, Filipino and Japanese family it must have attained second and third generation status in Hawaii. This criterion assured a removal in time from old country influences and time for exposure to cultural forces in Hawaii. (3) The woman must have had three or more children (reduced to two or more in the case of the few Chinese available to the study), the last birth having occurred within the past year. The criterion of three or more children was used to exclude the first pregnancies, which are apt to be more strongly dominated by grandparental influences due to the greater degree of dependency on the part of inexperienced mothers. The stipulation that the last birth had occurred within the past year was to aid recall. Most of the families in this study were clientele of the nursing service.

The method of interviewing was unstructured—the mother (occasionally both mother and father) was encouraged to tell what she did or believed was appropriate to the care of pregnancy, delivery, the newborn baby and the period immediately following delivery until she was restored to her full responsibilities as wife and mother. Interviewers were provided with a guide of areas about which information might be obtained, however, the nurse was not provided with the material from the early Hawaiian or the old country beliefs and practices on the premise that such knowledge might direct the interview unduly.

Following the collection of interview records the beliefs and practices were classified and tabulated.

The limitations of this research are apparent: the fact that the families knew the interviewers as nurses may have limited the reporting of beliefs and practices known to be unacceptable to health workers; and the number of nurses who contributed to the collection of data raises questions as to how skillful and comprehensive the process of the interview actually was in particular cases. The unstructured informal method of the interview elicited varying degrees of both omission and inclusion of information suggested by the guide. Nor does the number of families selected in each ethnic group approach an adequate statistical sample: the findings certainly have no statistical significance. Finally, the information is drawn largely from the agency caseload, which does represent a good cross section of the low and middle economic and major occupational groups in the Territory but does not, on the other hand, include the high economic and professional groups.

Despite these limitations, this investigation does provide valuable clues and impressions of cultural characteristics which continue to influence the health and care of mothers during the childbearing period. Furthermore, the findings provide a basis for further social research which can be designed for statistical validity and other refinements.

Dr. Andrew Lind was a strong motivating force at the start of this undertaking and his encouragement and counsel have sustained this project to completion.

with real spontaneity. Recall also seems to have been a factor, as well as the overlay of present day Christian religion and exposure to education in relation to modern medical practice.

Among the older Hawaiian women the attitude toward bearing children was a natural one: they were expected and accepted. Large families of ten, twelve or more children were common. However, it was a usual practice to share with relatives who were childless, or in instances where large families created economic hardship or deprivation. Grandparents might lay claim to the first born, the maternal grandparents if it were a girl and the paternal grandparents in case of a boy. Children were often promised to other relatives prior to birth; in either event, to relatives or grandparents, the intended guardians were present and assisted with the birth.

No significance was assigned to lack of fertility; however, it was thought *"hanai"* often solved the problem; perhaps with a child in the home, the woman herself might then become pregnant. Herbs were often used to promote pregnancy, but informants were unable to name them specifically. No attempt was made to avoid conception.

Reading indicates that physiological processes were in ancient times rather closely tied in with psychic phenomena, and vestiges of belief in malevolent influences in relation to illness, birth and death seem still apparent. This formerly was considered possible as a result of spite, hate or jealousy on the part of another person, the activity of ghosts, offended spirits, guardian spirits or ancestors, or acting against one because of one's commissions or omissions, acting against one for some other reason by their keepers; or the condition may be caused by withering, burning, soul-extinguishing power of concentrated suggestion emanating from someone who practices the black art for pay. To care for or counteract all of this the Hawaiians built up a great system of treatment, physical and psychic therapeutics.

In relation to the birth process in terms of the elders interviewed, there is no structured purifying process; but a vestige of the concept would seem to focus around the need, prior to delivery, to seek forgiveness from God for wrongdoing and from those whom the mother might have offended, clearing up any "hard feelings" and exerting especial caution not to criticize, scorn, or ridicule one who might in any way be afflicted. It appeared important that the mother have no enemies lest there be difficulty for mother and baby at birth.

Certain taboos were carefully regarded: wearing of leis, necklaces, scarfs or tight waist bands lest the baby become strangled in the umbilical cord. The hair was to hang loose at night. Ill luck was associated with pounding nails or sweeping after dark or sleeping in a doorway. Sewing and knitting were also taboo lest the baby be born with *"pukas"* in his body.

The common custom was to be delivered by members of one's family, the husband often taking the major role, or to be delivered by a midwife. Those who had the know-how and skill could determine prior to birth the position of the fetus and by means of massage and manipulation turn for head presentation. To promote an easy delivery, considerable activity was encouraged, particularly walking. Swimming in the early months was recommended, and sitting on the beach with thighs against the abdomen, allowing the surf to wash against the legs and body, was thought to make birth easier. Too much rest and excessive sleeping were considered detrimental; the baby became large and lazy and as a result delivery was prolonged and difficult. Intercourse was unrestricted, apparently on premise that it tended to keep open the birth passages.

The sex of children and sex of the first born were considered more or less a matter of individual choice. Some felt girls were more desirable because they could help with other children; others, boys, so that on reaching adulthood they could contribute to family subsistence; but a boy in any event, ordinal position not particularly important, in order to carry on the family name.

Numerous beliefs existed in relation to prediction of child's sex, the most common perhaps the mother's unconscious preference of left or right hand in reaching for an object, use of left or right foot first in changing from a sitting position to a standing one, or in stepping to walk: the use of right hand or foot meant it would be a boy, the left, a girl. Folds on the back of the thighs of the previous child were also considered meaningful in determining sex of an unborn infant: if uneven in number a boy might be expected, if even, a girl.

Twins were associated with eating of twinned fruits, also if husband and wife were particularly close and did many things together. With twins, the belief existed that they be separated at birth and reared apart, otherwise one or both would die. Birth before due time was attributed both to malevolent influences and physical factors, i.e., overwork, overexertion, lifting heavy objects, etc.

Certain foods were considered taboo during pregnancy on the premise they might give rise to birthmarks, apparently the mountain apple the most common offender. Beliefs regarding foods and food cravings, however, seem a confused issue, for either eating or craving specific foods

might cause discolorations or marks. Food cravings also were considered factors in influencing the child's nature and characteristics, and if the child were marked as a result, the site of the mark held significance; i.e., on the hand, he would be a good worker, on the forehead, intelligent, etc.

The mother's diet was rather well regulated after the third or fourth month; spicy and salty foods were omitted, as well as raw and bloody fish, and starches were avoided lest the baby grow large and lazy, thus making delivery difficult.

Normal social life and activities were maintained with the exception of attendance at funerals. Possibilities in this event were that the baby might be marked, or that the soul of the dead one captures the soul of the unborn, resulting in a stillbirth or neonatal death. Revealing existence of pregnancy or discussion of the matter held little or no significance for those oldsters interviewed, although reading indicates that in ancient time pregnancy was a carefully guarded secret lest the mother fall prey to jealousy or the curse of enemies, and become the object of malevolent supernatural forces.

Undue fatigue and irritability were the only indications elicited that delivery was imminent. Giving the white of an egg was thought to lubricate the birth passages and thus hasten delivery; so was stimulating the gag reflex to induce vomiting. Difficult delivery was tied in with existence of ill feelings with others, so prayers were said to ask forgiveness from God by members of family gathered to assist with the birth. The mother was encouraged to remain on her feet during contractions, finally assuming a squatting or kneeling position, a relative or husband placing knees against her back with arms tightly grasped around the upper abdomen with another person in front supporting knees with knees and tightly grasping the mother's hands.

A warm drink was given following birth, frequently whiskey, to stimulate expulsion of "old blood." A solution of Hawaiian salt was used as an antiseptic when tearing had occurred. Careful disposal was made of the placenta; usually it was buried deep in the earth so that animals could not get at it, and a fruit tree planted on the site. The baby was put to breast when the mother was rested. The dried umbilical stump was carefully guarded, sometimes put in a bottle and thrown into the sea, sometimes buried in deep rock crevices, and sometimes kept in the home in a safe place. Such care was extremely important lest rats get at the stump, in which event it seemed the child was doomed to become a thief.

Lactation was promoted by giving soups—chicken or fish—often with ginger root added. The sweet potato vine was wound around the neck and left until the leaves wilted to increase the milk supply. During first two or three days prior to establishment of flow, the mother chewed raw sweet potato and placed this on the infant's anterior fontanelle. This was believed to provide interim nourishment. Babies usually were breast fed through the second year. Often to dry up the breasts a metal house key was hung on a cord around the mother's neck.

Post partum restrictions and resumption of routine activities, in relation to those interviewed originally, varied considerably.

The baby was baptized in time, according to the tenets of the church or religion with which the family was associated. Naming of the infant seemed to bear significance; often the name came to one of the parents in a dream, often was given to honor someone whom the parents admired especially. The Hawaiian name was usually selected by an older member of the family, care taken to avoid that of an *alii*, this being taboo unless the child were in chiefly line, since otherwise harm would befall him. The name often was associated with some major event which took place simultaneously with the child's birth.

The baby *luau* at one year was an important social obligation, largely an expression of joy and gratitude on the part of the family that the infant had survived the hazards of birth and the rigors of the first year of life. Friends and relatives were invited.

How much hangover remains of these old cultural practices; how much is overlaid or fused with modern day medical practice, current religious beliefs; and how much results from cross-culture, gives rise to interesting speculation. The tabulation of data acquired in subsequent interviews with women now of reproductive age reveals much additional material in terms of folklore related to child bearing, but an interesting aspect of this is that though certain practices and beliefs are regarded with more or less importance, the underlying reasons for these have been lost. Additionally it seems that health education, though many misconceptions appear, has cut through many old customs and beliefs.

The size of the family is now more carefully considered than in the older group with varied means used toward contraception. To aid conception, remarks revealed no well defined beliefs.

In regard to sex determination, numerous additional beliefs appeared; however, handedness remained an important device, though confused in terms of the original—right, a boy; left, a girl. No especial significance was attached to sex of

the child except that there be a boy to carry on the family name.

Twins were generally assigned to a hereditary factor; stillbirths appeared to be tied in with superstition; deformities and birthmarks, too, when any belief existed, were associated with old folklore. The taboo on wearing leis, necklaces and tight bands still holds rather intact on the premise the infant may be strangulated in the umbilical cord.

Study of the tabulated data would seem to indicate considerable influence in relation to supernatural forces, but it is curiously mixed with religion: curses, kahuna powers, etc., being counteracted by prayers, asking forgiveness, etc. (Of 54, 29 stated no belief, 7 made no comment; of the specific remarks, 1/3 were associated with a fusion of supernatural forces and religion.)

Practice of massage with oil or Hawaiian salt solution still holds; however, manipulation of the baby's position appears to have sloughed off. Hygiene fits in fairly well with current patterns in health education with the exception of rest. The belief clings that if the mother's rest is not limited the baby will grow fat and lazy in the uterus, and thus make for a difficult delivery. Principles of good nutrition have been fairly well assimilated, though specific remarks give evidence of existing misconceptions.

Hospital deliveries are preferred, though a number of those interviewed held to home delivery with vehemence. As with the elders, initiation of medical supervision is rather a casual matter, care for the most part being delayed until rather late in pregnancy. Early preparation for birth similarly was delayed lest it precipitate untoward events—death of baby, bad luck, etc.

No specific structure seems to hold in relation to employment, social activities, or discussion of pregnancy. Overwork, overexercise and overexertion were considered deleterious and to be avoided.

Proper disposal of the placenta and cord stump remain rather intact in the consideration of present-day mothers, though deliveries are at the hospital for the most part. Primary aim is for animals not to get at either, or the child will be a thief. The old custom of burying the placenta and planting a tree at the site is recounted, the tree fruiting abundantly as a result; an additional reason was that if it were buried in the yard, the child would not wander from home.

Naming has lost much of its old cultural significance, being sloughed off to a matter more or less of individual choice. The baby *luau* seems also to have lost its meaning, something which is to be done, but which maintains little of its original significance.

Tabulation and study of data collected in the interview process reveals much rich imagery, but actually very little is fundamentally opposite to modern medical practice. Two features, however, pose questions; namely, the rather casual attitude toward seeking supervision early in pregnancy, and the feeling that "too much rest or sleep" predisposes to a difficult delivery. Both education and exploration of individual situations might well be considered means to prevent possible untoward results in either event.

An awareness, understanding and acceptance of many of the apparently innocuous beliefs, practices and customs would seem a real asset on the nurse's part in terms of acquainting herself with families and in terms of establishing friendly effective relationships. When misconceptions exist and collide with adequate, accurate information re: the reproductive process, knowledge and acceptance of these is a forward step in changing the patient's attitudes and often distorted ideas, which have arisen out of their cultural structure.

(To be continued)

A TALE OF TWO PATIENTS*

"This is Dr. Smith calling. I have a terminal cancer patient who requires home nursing care. Will you visit and advise the family as to the care of this patient? By the way, the patient does not know that she has cancer . . ."

"This is Dr. Brown calling. My patients' routine cytology test revealed many atypical cells, suggestive of cancer. I would like to recheck her to see if cancer of the cervix is present, but I have not been able to get her back for another examination."

These are two examples of the types of cases referred to us at the Hawaii Cancer Society for home follow-up. We are both health educators and have been rendering home nursing-welfare service to patients when requested. Our past experiences in public health nursing are immensely helpful in the home follow-up of such cases. The public health nurses of the Territorial Department of Health also render similar services to cases referred to them.

This presentation is not a detailed case study of two patients. It is merely an attempt to point out the importance of early detection and prompt treatment of cancer patients. The successful control of cancer usually depends upon early and adequate treatment before the lesion metastasizes. Time is a very important factor and is often called the common denominator of cancer. Every cancer patient is a great challenge to the nurse and calls

* Ines V. Cayaban, R.N., and Clara S. Ishikawa, R.N., Health Educators, Hawaii Cancer Society.

for the best nursing care. Much can be done for even the terminal cases.

Here are two patients: one is beyond medical help; the other has hope for cure if immediate medical attention is given. Our approach to each patient will obviously be different. One will require highly skilled nursing care, both physical and psychological, so that the remainder of her life will be as comfortable and happy as possible. The other case requires much tact and encouragement so that she will see the importance of an immediate recheck. There is no diagnosis as yet, but if this should turn out to be cancer, early diagnosis and prompt treatment are essential. Any fears that the patient may have regarding her condition must be allayed and care must be taken that the possibility of cancer being present is not suggested to the patient.

When visits are made to apprehensive patients, mention of the Hawaii Cancer Society is avoided. The visitor presents herself as a nurse sent by the attending physician. She does not wear a uniform or carry any nursing bag. Our follow-up on these patients is presented with our observations and comments.

Dr. Smith's Case

Mrs. A is a 50 year old Japanese woman with cancer of the sinus. A series of x-ray treatments were given by a radiologist about a year and a half before referral to us. The results were good with temporary remission of the lesion. Three months previous to our initial visit, Dr. Smith noticed a tumor in the left nostril and x-ray treatments were resumed. This time there was no remission and palliative measures were started. The family was told there was no hope for recovery, and Mrs. A should be made as comfortable and happy as possible.

It is generally known that the chronic nature of cancer and its many distressing features impose serious burdens upon the patient and her family, physically, psychologically, economically. These are particularly heavy in incurable and terminal cases. The psychological sequels of prolonged invalidism due to cancer sometimes present more acute problems than the disease itself. Trying to minimize these problems requires the utmost skill in nursing on the part of the family as well as the visiting nurse.

On our first visit to Mrs. A, she was in bed and appeared to be having considerable pain. Her discomfort was aggravated by obstruction in her breathing. She complained of severe pains around her nose and in her forehead. There was considerable discharge of thick purulent matter from the left nostril, which was removed with a cotton swab at frequent intervals.

Because Mrs. A was in pain, our visit was shortened and an attempt was made to give her as much encouragement as possible. We felt that words of encouragement meant as much to Mrs. A as the actual therapy. When we learned that Mrs. A was from one of the other islands, we talked about people we knew on that island. Her eyes brightened as we talked of mutual acquaintances. Mrs. A's emotional state may have been due to fear of death coupled with fear of being a burden. Mrs. A was encouraged to pursue her normal way of life and continue as a contributing member of her family circle as long as possible. Occupational therapy was suggested as a leisure activity because of its tremendous value in combating fear, suffering, and dejection.

We spent a great deal of time with Mrs. A's daughter, who was taking care of her. We felt that the daughter needed as much as, if not more, encouragement than Mrs. A. She recognized the facts and understood what lay ahead. In addition to this, she had to be cautious so that her expression, manner, or action did not arouse her mother's suspicion. She was shown some of the simple nursing techniques so that she could conserve her energy and protect her own health. Her adjustment to the problem was good but she needed moral support to face the inevitable end ahead. Many hours were spent discussing her problems and ideas and giving necessary encouragement and advice. The daughter realized that death was more merciful than prolonged suffering. The patient expired at home about three months after our initial visit.

Dr. Brown's Patient

Mrs. B, a well-built Chinese woman in her early thirties, answered my knock. She had just returned from work. After an exchange of greetings, I proceeded into the purpose of the visit.

"It is necessary to recheck the test performed during your last examination and Dr. Brown is anxious to have you return," I said. Naturally Mrs. B was concerned. "What was wrong?" I explained that sometimes it is difficult to draw definite conclusions from one test and further tests may be necessary. In this case, the time element was important. Mrs. B said she would contact Dr. Brown immediately.

Mrs. B saw Dr. Brown the following day and arrangement was made for a biopsy. The pathologist reported that a cervical biopsy had revealed the presence of cancer. The diagnosis was "in situ squamous carcinoma of the cervix."

Mrs. B has been treated and watched closely by Dr. Brown. The subsequent cytology tests have been negative. She will continue to be fol-

lowed by Dr. Brown at intervals for several years to come. Dr. Brown believes Mrs. B has an excellent chance for cure since her cancer was found even before any symptoms were present.

The foregoing is a tale of two patients: one ended in tragedy; the other, in happiness. Cases like Mrs. A's are much too common today, partly because the diagnosis is made too late. Although much progress has been made in cancer control, our only hope for cure in most cases is early diagnosis and prompt treatment. Great strides are being made in cancer research and better diagnostic and therapeutic methods are being discovered. There is more hope today that many cancer patients will be treated successfully.

The program of the Hawaii Cancer Society is aimed toward the control of cancer by early detection and prompt treatment. Our best weapon so far is an informed public as well as informed professional personnel.

Every nurse has a major role in this fight against cancer. Regardless of her special field, the very nature of her work makes her a potential force in cancer control. Her role in early case-finding cannot be overemphasized. Every nurse should be familiar with present day methods of diagnosis and treatment. She should know that every cancer patient can be helped and many can be cured. A well informed nurse will not only have an optimistic attitude toward cancer, but will help instill this attitude in the patient and her family.

THE UNIVERSITY SCHOOL OF NURSING IS REVIEWED FOR ACCREDITATION

Two and one half years after its establishment, the School of Nursing at the University of Hawaii has been reviewed for temporary accreditation by the National League for Nursing. The purpose of this preliminary review is to estimate the school's potentialities for meeting full accreditation requirements and to make suggestions for development toward that end. Mrs. Mary Tschudin, Acting Dean of the School of Nursing at the University of Washington at Seattle, was the visitor assigned by the National League for Nursing to make the evaluation visit. At the request of the University, this evaluation visit for nursing was made as a part of the review of the entire University by the Western College Association. Mrs. Tschudin was a member of the visiting team of eight, with all team members sharing and evaluating findings.

In connection with her visit, Mrs. Tschudin called attention to certain factors which she considered outstanding in the potentialities of the school at the University of Hawaii. First in importance she believed was the fact that the School of Nursing is an integral part of the University, with adequate budget provisions, cooperation and assistance from other University departments and opportunities to function in every respect as do other University units. Of great significance to the development of the program also, she stated, is the fact that the school is starting out with the understanding that students are not to be depended upon for service in the practice fields. Another factor which bodes well for the program is the sincere desire of field agencies to contribute their facilities to the program.

Mrs. Tschudin reported that many collegiate schools are still struggling for full university recognition and adequate financial support as well as adequate field facilities. "With these three essentials assured," Mrs. Tschudin commented, "the School of Nursing at the University of Hawaii has unusual potentialities for development into a true collegiate program."

Certain suggestions were made in relation to organization and curriculum. She urged an increase in the proportion of general education courses. At present slightly more than one-third of the credits are given for courses in general education. The recommended proportion is one-half. Further evaluation of student achievement in clinical practice and continuous evaluation and integration of the content of nursing courses, will, in time make this proportion possible.

Full and earlier use of Maunalani Hospital for initial student practice was recommended since it offers a most desirable opportunity for experiences not available in most mainland schools.

Mrs. Tschudin encouraged the development of plans for a supplemental program for graduate nurses leading to a Bachelor of Science degree in Nursing which will give more recognition to the three-year professional program. Such a plan is now under consideration.

With this encouragement and help, review for full accreditation will be welcomed after the graduation of our first class in 1956.

VIRGINIA JONES, R.N.
Director, School of Nursing
University of Hawaii

PUBLIC HEALTH SECTION NEWS

The Fact Finding Study Committee of the Public Health Section, NATH, has made an investigation of areas suggested by Dr. Thomas Ige and Mr. Charles Kendall during the section meeting at the last annual meeting. The data will be compiled and a copy will be sent to the NATH Economic Security Committee. Other sections are invited to look over the material if they so desire.

The committee, chaired by Miss Darlene Kubota of the Veterans Administration Clinic, has been working since November, 1954. The investigation has been geared around public health nursing. Subcommittees were formed to implement fact finding. The subcommittees and the chairmen are:

1. Historical comparison of the cost of living with PHN salaries—Frances Nakamura, Chairman
2. Historical comparison of salaries of Department of Health nurses with salaries of nurses in positions in institutions or other agencies in the area (T.H.)—Lillian Mau, Chairman
3. Historical comparison of salaries with salaries of nurses in similar PHN positions in other states—Lorraine Ishikawa, Chairman
4. Historical comparison of salaries with salaries of non-nursing occupations in Hawaii—Susanne Medeiros, Chairman
5. Legislative Aspects—Alavana Lee, Chairman
6. Supply of PHN in Hawaii—Marion Kwock, Chairman
7. Re-examination of job content, changes in work load—Nora Shiroma, Chairman

What can be done to make the public health sections more efficient and effective?

Recognizing this problem, the executive committee of the Public Health Section, NATH, has issued to the district public health sections copies of the ANA *Manual for State Executive Committees.*

The guide describes the duties of the executive committee and section officers to the state association board of directors, to each other, to section members, to district sections, and to the voting body of the state association. It contains a sample budget, adaptable to the needs of the state section. Also included in it is "Suggestions to Chairmen of Committees" drawn by the Washington State Nurses' Association.

Prediction of the year: The public health sections will not stay dormant!

KAZUE MCLAREN, R.N.

PROTECT YOURSELF

Applications for enrollment in the Hawaii Medical Service Association are due *April 15*. This opportunity is possible through your membership in the Territorial Nurses' Association. Take advantage of it now! Write or call:

HAWAII MEDICAL SERVICE ASSOCIATION
Honolulu—1154 Bishop Street—Telephone 5-3975
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An exclusive buying service is to be made available to NATH members. Each member will receive a 64 page catalog of nationally advertised merchandise.

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Here is an opportunity for nurses to save money through association membership. Tell your friends about it. A membership list will be sent to the company the latter part of March.

NEWS FROM YOUR HEADQUARTERS OFFICE

The Public Health Nurse Section is working, telephoning, conferencing, and holding committee meetings in order to get its standards set up in time for the legislature.

The Margaret Jones Committee met in January to review the annual report submitted by the Trust Company. Income this year from dividends and interest totaled $1,634.75.

The Nursing Information Committee met in January to make plans for the year.

The association received lovely Christmas greetings from 16 states, from ANA, from Congresswoman Frances P. Bolton, and others from individuals to all of whom we extend our appreciation.

Miss Olga B. Frojin, Nurse Recruitment Officer, Office of Medical and Nursing Service, Department of Hospitals, City of New York, was visiting in Honolulu and stopped in the office to learn what the Territorial nursing situation is. Her chief function is recruitment for schools of nursing. Following a newspaper article about her, several nurses called her to inquire about nursing on the mainland, and Punahou School asked her to speak to a class on nursing.

Is there a lesson in this for us on the value of publicity?

ABSTRACTS FROM LETTERS

Helen Gage, Jerusalem and Jordan:

"I am glad that you all miss me. I shall be back in 1956, so don't solve all of the problems before I get there. I don't think I shall learn a lot here about nursing, but maybe I can use some of the things that I know. I plan to go down to the American Colony Baby Hospital in the Old City soon and ask to help them. They are supported by voluntary funds from the U. S. and take in any baby, rich or poor. They have a well baby clinic as well as their hospital. I visited them one day and, as far as I can see, most of their cases are poor starved kids. They get some help from UNWRRA such as powdered milk, etc., so can get them on their feet to go home—to nobody knows what, I guess. It has been many years since I have seen such cases. One thing about this hospital, they keep all of their charts in English, the Director of Nursing has had a graduate course in Boston, and I feel that I can help and not have to struggle so much with the language barrier. In the clinic in Amman where I helped out, I had to have an interpreter, and you have to get one who understands medicine and nursing to do much good. They have a little student program of their own here, and are teaching in English so are anxious for the girls to use it. I shall write you all about it when I get started.

"Christmas here is a tourist job. They flock in here for Christmas and Easter. The big thing is the midnight mass at Bethlehem, and if it is as cold as it is now, it won't be any fun as these are old world churches with standing room only. The weather here is somewhat like Southern California in the winter—not too cold, but very damp and clammy. The houses and all of the buildings are of stones and lined with plaster and they retain the damp and you just can't get warm. The floors are all tile and very cold, and nobody has enough rugs. I can see why they developed the Persian rugs—they had to make them thick to keep their feet from freezing.

I have bought Tommy woolen socks and am about to go down and get me some of the knee length woolen ones which I see the little girls wearing to school. Those over a pair or two of nylons should just about do it."

Aiko Yano, Washington, D. C.:

"Believe it or not, here at Children's there are three nurses from Hawaii and we are representing the three nursing schools of Hawaii. Miss Joe Braz, a graduate of St. Francis Hospital, is head nurse on post polio ward; Mrs. Oki (Kubokawa), Queen's graduate, works part-time from 6-12 p.m. about three to four days a week, and is working in the Out-Patient Department. Mrs. Oki came up to me and asked me if I was Miss Yano of Kuakini. It was so good to see them. They send their Aloha to all."

Alison MacBride, Chief, Bureau of Public Health Nursing, Territorial Department of Health. Manila:

"WHO is really helping the nursing profession to raise the educational and practicing standards and, since the status of women is so low in many of these countries, it is well that there is this outside stimulus and help available from an International Organization. It works somewhat like this: the Nursing Advisor of the Regional Office staff is invited by the chief government nurse in a country to visit and they, together with other key nurses, discuss what help is needed in the way of technical experts from WHO and equipment and plan the educational program in which this assistance is to be given. The government then makes the request to WHO officially. Part of the agreement between WHO and the country is that there will be a counterpart person who works side by side with the WHO consultant and is trained to carry on the program after WHO withdraws. This counterpart, if she needs a better basic foundation in nursing to carry on the project, often is awarded a WHO Fellowship to study in the U.K., U.S., or some other country where the training is available. These projects last anywhere from two to five years.

"Some of you know about the Nursing Education Project in Taiwan, where WHO nurse educators are helping Stella Chen and her faculty build up the University of Taiwan School of Nursing to a college level school. Eleanor Bowen of Boston University has just arrived to be the new WHO team leader (Stella's counterpart). This project has developed the first up-to-date nursing manuals that Chinese nurses have had since before the war. The manuals are printed in English and Chinese and have been written by the Chinese nurse instructor and the WHO counterpart instructor and there is a manual in pediatrics, obstetrics, general nursing, midwifery, with one in medical and surgical nursing which is to be finished in 1955.

"Another example of WHO's assistance to nursing education is the project scheduled to start in 1955 in Japan: Japan has asked assistance to organize a post-graduate education program at the National Institute for Public Health in Tokyo, which will prepare nurses for teaching positions in the 119 schools of nursing, the 9 midwifery schools and the 13 public health nurse schools. The Japanese Nurses' Association made a survey of nursing manpower requirements and needs (similar to the one we did) in 1954 and it was clear that very little could be done to improve nursing standards until there was adequate preparation of teachers. Those of you from Wayne or Michigan will be interested to know that Katherine Lyman has been employed as the WHO Nurse Educator Consultant to develop this education project.

"Yesterday I spoke to the Filipino Nurses' Association about WHO's work in behalf of nursing (they get a good crowd out for 2:15 p.m. meetings). They are very close to us and keep an eye on American nursing developments. Miss Annie Sands, Mrs. de Guzman, Mrs. Buenafe, and Miss Sirilan send greetings to their friends in Hawaii.

"Last week I slipped around through a muddy rice paddy in a rural district adjacent to Manila, to accompany a PHN on a home delivery. The PHN here is also a midwife when she has completed 20 home deliveries. The home was a tiny nipa hut and the mother delivered on the floor on a straw mat—the other three children (2, 3, and 6) sat on the floor watching and were as good as gold and delighted to have a new boy 'sanggol.' This mother had had untrained village midwives (hilots) for her other deliveries but this time she had called the health center nurse because a neighbor had died at childbirth due to a hilot's interference. (The hilot had done an episiotomy for a mal-presentation). WHO has placed a British nurse midwife in the Philippine Health Department to assist in a training program designed to make these hilots safer practitioners—they deliver 75% of the babies.

"At this point, I do not have much to say about the other kinds of programs in the countries in which WHO is assisting. These are concerned with the control of schistosomiasis, yaws and we have BCG vaccination teams working in several countries. There are MCH, rural health demonstration and environmental sanitation programs as well. WHO PHNs are working with the MCH, PCG Treponematoses and rural health training teams. More about these later.

"The most stimulating event of the month was the WHO Regional Committee meeting which met for a week in Manila. The committee, which is composed of representatives of each government participating with WHO in the Region, met to review the Regional budget and program for the next two years. Dr. Lee was the chief U.S. delegate and played an active part in the work of the committee. This gave me a very close view of the relationship between the governments and WHO and was better than reading all the documents on file in providing good orientation to WHO. The Regional budget next is presented, along with the other four Regional budgets, to the WHO Health Assembly which gives it final approval at the May meeting.

"The principal job I was to do with WHO concerned preparations for the Nursing Education Seminar next July in Fiji. (We have to call it a *seminar* since outside U.S. a 'workshop' means a place where one is employed in manual arts!) The nurses in this region have asked WHO to hold a seminar every two years in a long range program to assist nursing to develop and this next one is the second. It will be concerned with (1) the use of clinical facilities in teaching students; (2) how to develop postgraduate educational programs (tutors, ward and hospital administration, public health nursing, etc.); (3) the relationship between administration and schools of nursing; (4) the training of assistant (practical) nurses and assistant midwives—which constitute the largest group of nursing practitioners in many countries. About 40 nurses from countries in the Western Pacific Region will be awarded WHO Fellowships to go to Fiji—from Japan, Korea, Taiwan, Philippines, Malaya, North Borneo, Singapore, Cambodia, Vietnam, Laos, New Zealand, Australia, and several Pacific island possessions of governments with seats outside the region —it's too bad Hawaii isn't in the Western Pacific Region

so that two of you could go to Fiji! Mr. Frank Drees of our DPI is to be Educational Director and other consultants will be Katherine Lyman (University of Michigan), Nurse Educator; Mr. Adams (Suva) as Educational Psychologist; Dr. Jean Craig (National University of Australia) as a Social Anthropologist and six WHO nurses working in nursing education projects in countries in the region. It is amazing how helpful the 1952 seminar has been in stimulating nursing progress—it was followed in four countries by a workshop sponsored by the nurses' association, which spread seminar concepts and recommendations widely within the country, and the Regional Nursing Advisor in her visits has seen positive developments in countries since 1952. Fortunately (for me), part of my job was to visit Fiji and assess the accommodations available to the seminar and work with the local Arrangements Committee on their part of the preparations. They will open the new School of Nursing buildings to us and the hillside site, overlooking Suva Harbor, will be a most congenial setting. At the rate the committee was planning hospitality for the participants, I thought I was back in Hawaii!

"The Fijian Islands have a natural beauty very much like Hawaii and the Fijian people have the proud carriage, gentle manner, and fishing proclivities of our Hawaiian. There is, however, racial tension between the two major population groups, the Indians and Fijians, who have not intermarried. This seems to have economic origins. When Fiji became a British Crown Colony in 1874 by cession, the agreement was that the Fijian would own all the land, which he still has in his possession to a large extent, although it is not fully used. The Indian was brought to Fiji as an indentured laborer for the sugar plantations and at the end of his contract left the plantation to climb the economic ladder outside. He has succeeded in the merchant class, believes in education for his children and is ambitious for them but finds economic expectations are contracting each year. The government services are spread thinner and thinner as the population increases and the tax revenue remains static. The visitor to Fiji becomes aware of this tension very early from the anxious European minority.

"On the return trip, I stopped over in Sydney and we can take a back seat when it comes to those enormous Sydney beaches, although the sharks are not as friendly down under. The world's best zoo (particularly the Koala bears and colored birds) claimed several rolls of film one Sunday. The serious side of this visit had to do with the officers of the New South Wales College of Nursing and the public health nursing course they are starting next year (the first public health nursing preparation offered in Australia). We had to look this program over since WHO sends nurses on fellowship for postgraduate work to this college as well as the Melbourne College. Nursing has a hard row to hoe down there; there is such a manpower shortage on all sides in Australia that many other occupations beckon young women which require little or no preparation and give as good job satisfaction and salary as do teaching and nursing. Hospitals are short staffed and the nursing service is largely carried by students. The Australian Nurses' Federation plans to do a nursing survey next year upon which to base national planning for educational programs and service needs.

"Since returning to Manila, I have been busy recruiting nurses for a nursing education program in Singapore, a public health nurse-midwife needed on the WHO team helping develop a rural health training center in Jitra, Malaya, and a general nursing tutor to help strengthen a school of nursing in Cambodia. UNICEF gives these projects good assistance by providing equipment and textbooks for schools of nursing. Did I tell you in my last letter that the school at Ponape (where Agnes Saddler teaches) will have WHO assistance next year, a midwife tutor and a fellowship program for the faculty? Another new project is in Japan to develop the postgraduate training program for nurses at the Institute of Public Health in Tokyo; WHO will assist by assigning a senior nurse educator and fellowships for some of the faculty to study overseas.

"It's been a wonderful experience to be a member of the organization even for three months and to see how much WHO is doing to help nursing develop better professional standards in some of the more backward countries."

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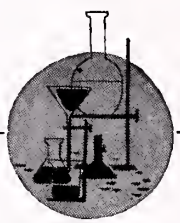
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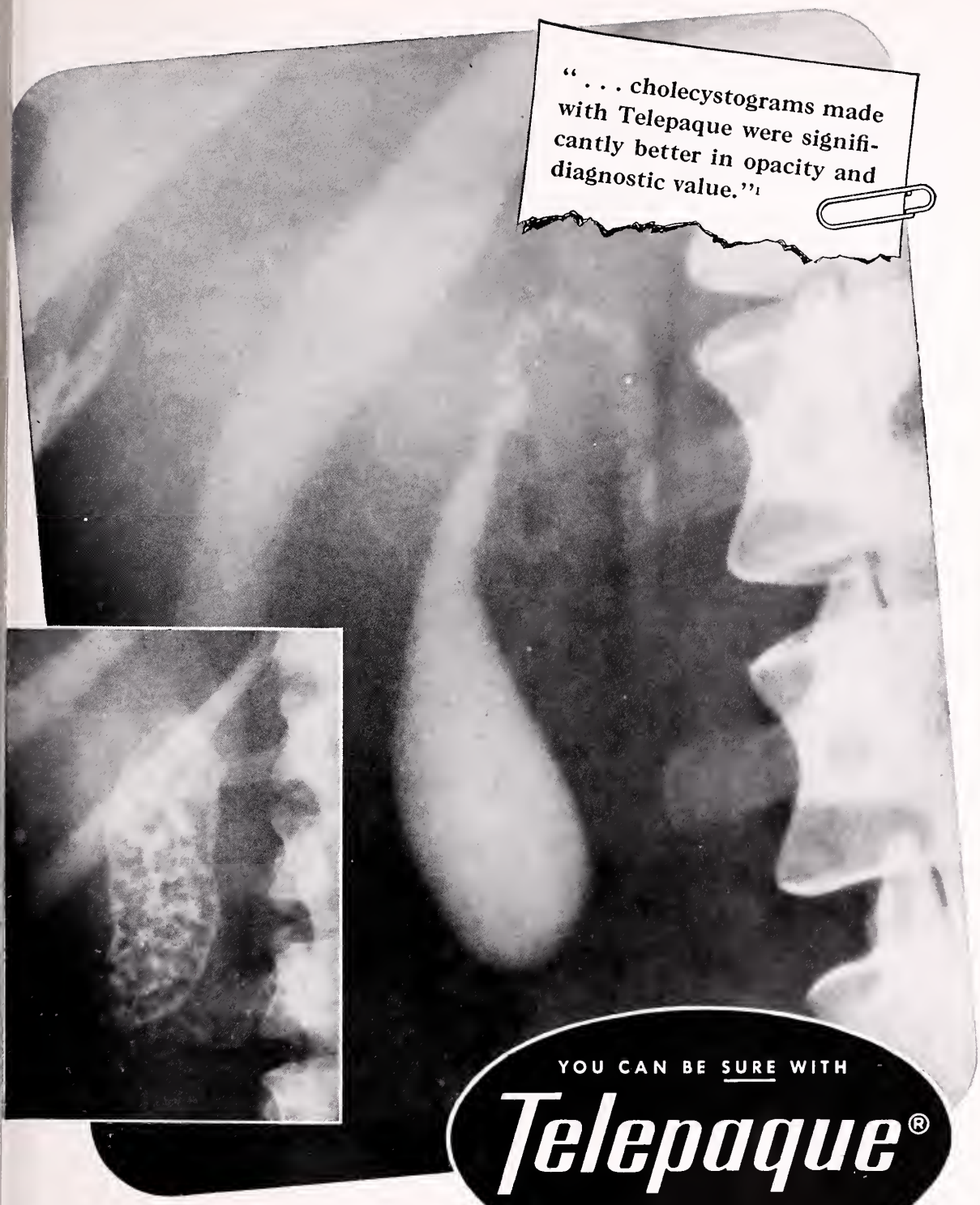
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1 Abel, M.S., Lomhoff, I.I., and Garcia, C.V.: Permanente Found. Med. Bull., 10:95, Aug., 1952.
2 Lowman, R.M., and Stanley, H.W.: Connecticut Med. Jour., 16:591, Aug., 1952

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GASTRIC CARCINOMA

(*Continued from page 298*)

Conclusion

Biologic behavior acting as a mirror or indicator of neoplastic growth is the significant factor in determining prognosis. Early diagnosis, radical extended surgery, and increasing operability and resectability are of peripheral value in increasing survival rates in patients with gastric cancer, though they should be fully exploited. The need for identifying factors other than these three is imperative if survival rates in gastric carcinoma are to be significantly improved.

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1. Macdonald, I. Biological Predeterminism in Human Cancer, Surg. Gynec. & Obst. 92:443 (April) 1951.
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MEDICAL ECONOMICS

(*Continued from page 321*)

whereby we will do the billing, collecting and bookkeeping for our members on a fee basis. In this way the doctors will be relieved of all of the burdensome work connected with the business side of their practice and will be free to devote their full time to their practice. Statements go out on time and the proper follow-up on accounts receivable is maintained. The public will benefit from the application of business methods and our doctors will benefit from higher collections earlier as well as being given more freedom in their practices.

R. M. KENNEDY
Executive Secretary

OAHU PRISON

(*Continued from page 319*)

ality." Quoting from the diagnostic manual of the American Psychiatric Association: "This term refers to chronically antisocial individuals who are always in trouble, profiting neither from experience nor punishment, and maintaining no real loyalties to any person, group or code. They are frequently callous and hedonistic, showing marked emotional immaturity, with lack of sense of responsibility, lack of judgment, and an ability to rationalize their behavior so that it appears warranted, reasonable, and justified."

Oahu Prison's need for more psychiatric help is fully recognized by local and national authorities. Emphasis should be placed on the improvement of relationships between staff and inmate body. This could partly be achieved by an educational effort aimed at increasing understanding among all categories of people associated in the daily existence of the prison and associated projects. It is felt that a psychiatrist, well trained and personally interested in this subdivision of psychiatry, would be essential to bring this ideal program to eventual realization.

ROGER H. DENNETT, M.D.

BOOK REVIEWS

(*Continued from page 328*)

Because of the book's physical excellence, the publishers deserve congratulations. The type is clear and there is an abundance of superior illustrations (drawings, photographs, and photo-micrographs).

No single book can possibly be an encyclopedia of oncology. Nor is this work. However, it is probably the most important single work of its kind, and deserves a place in the library of all practicing physicians. For while it cannot be complete, it offers a sound basic concept of malignant disease thus serving as an important wharf from which one may depart to journey the seas of literature investigation.

GROVER H. BATTEN, M.D.

Also Received

Surgical Clinics of North America.

December 1954—Obstetrics and Gynecology, pp. 1493-1781, figs. 336-401, $18 per clinic year, cloth binding, $15 per clinic year, paper binding, W. B. Saunders Company, 1954.

Philadelphia number. Symposium on obstetrics and gynecology, with a supplementary article on prostatectomy.

Modern Medical Monographs—Physiologic Therapy for Obstructive Vascular Disease.

By Isaac Starr, M.D., 38 pp., Price $2.50, Grune & Stratton, Inc., 1953.

A valuable practical manual on the management of peripheral arteriosclerosis by one of America's great internists.

The Shoulder and Environs.

By James E. Bateman, M.D., 565 pp., illustrated, Price $16.25, C. V. Mosby Company, 1955.

All about the normal and abnormal shoulder and the surrounding structures in over 500 pages, with 376 diagrams, operative and anatomical drawings and roentgenograms, by an eminent Canadian orthopedist.

An Historical Chronology of Tuberculosis.

By Richard M. Burke, M.D., F.A.C.P., Second Edition, 125 pp., Price $3.75, Charles C. Thomas, 1955.

A thumbnail chronological history of tuberculosis. Fascinating to phthisiologists and historians alike.

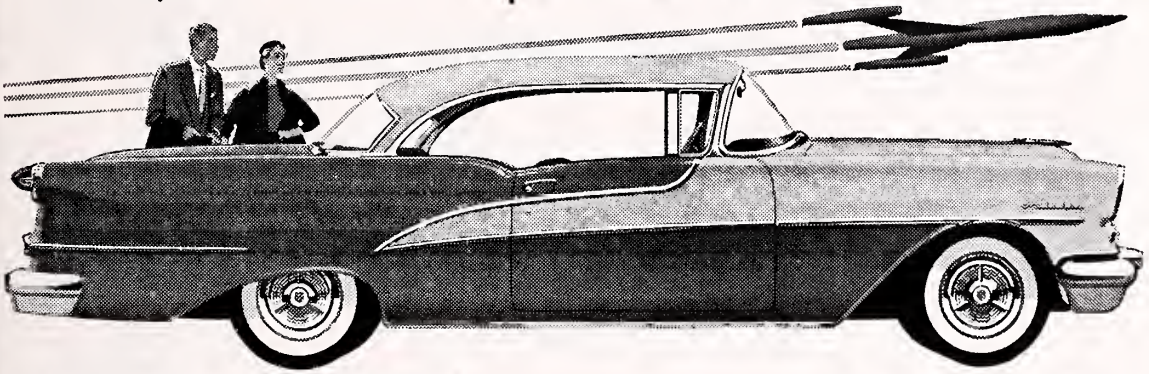


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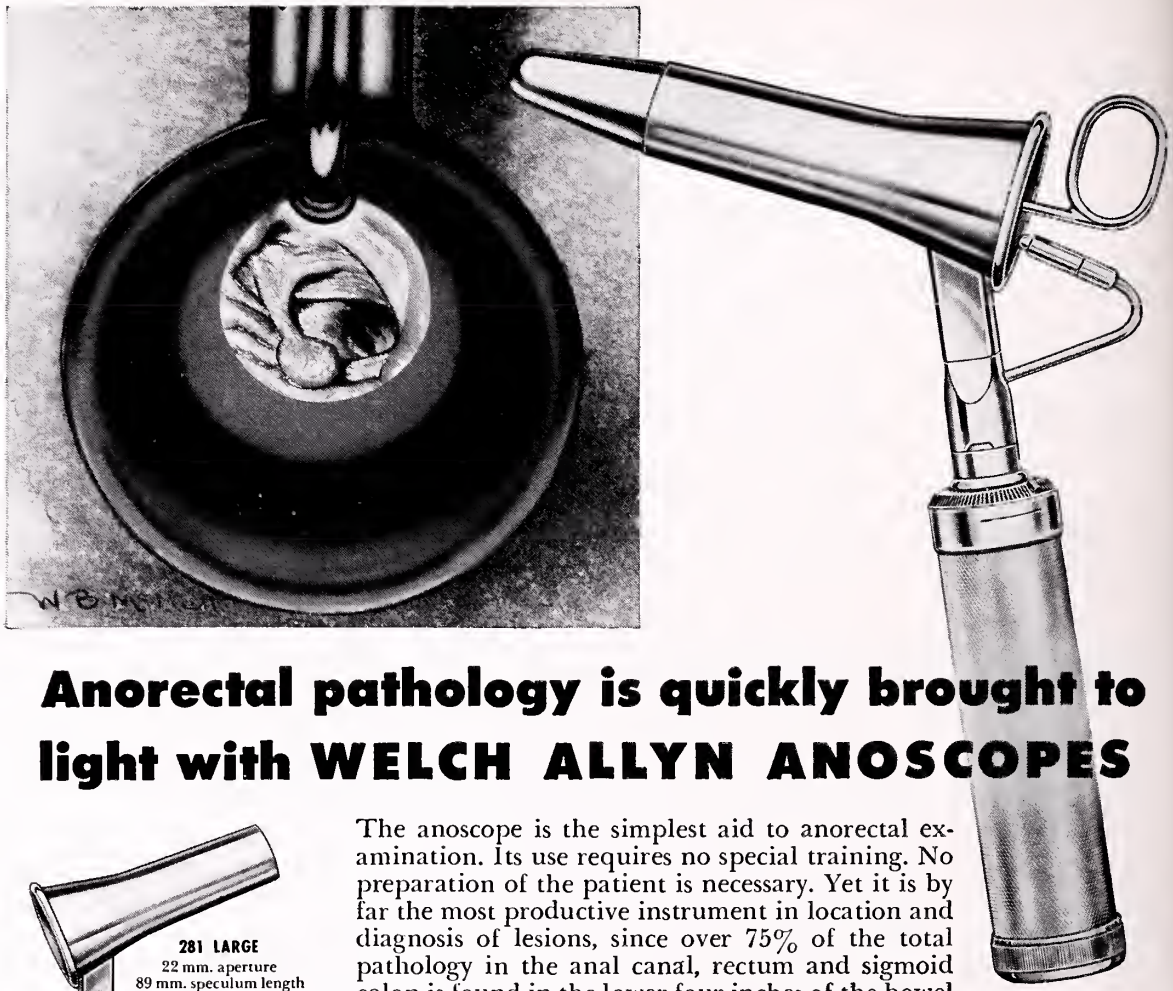
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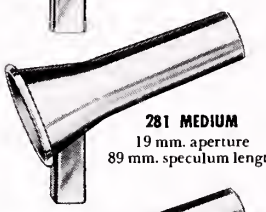
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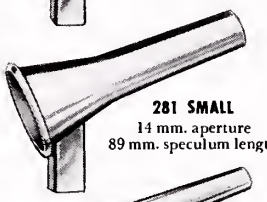


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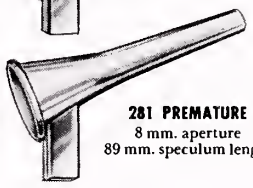
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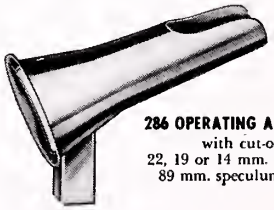


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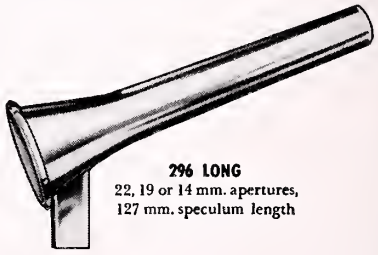
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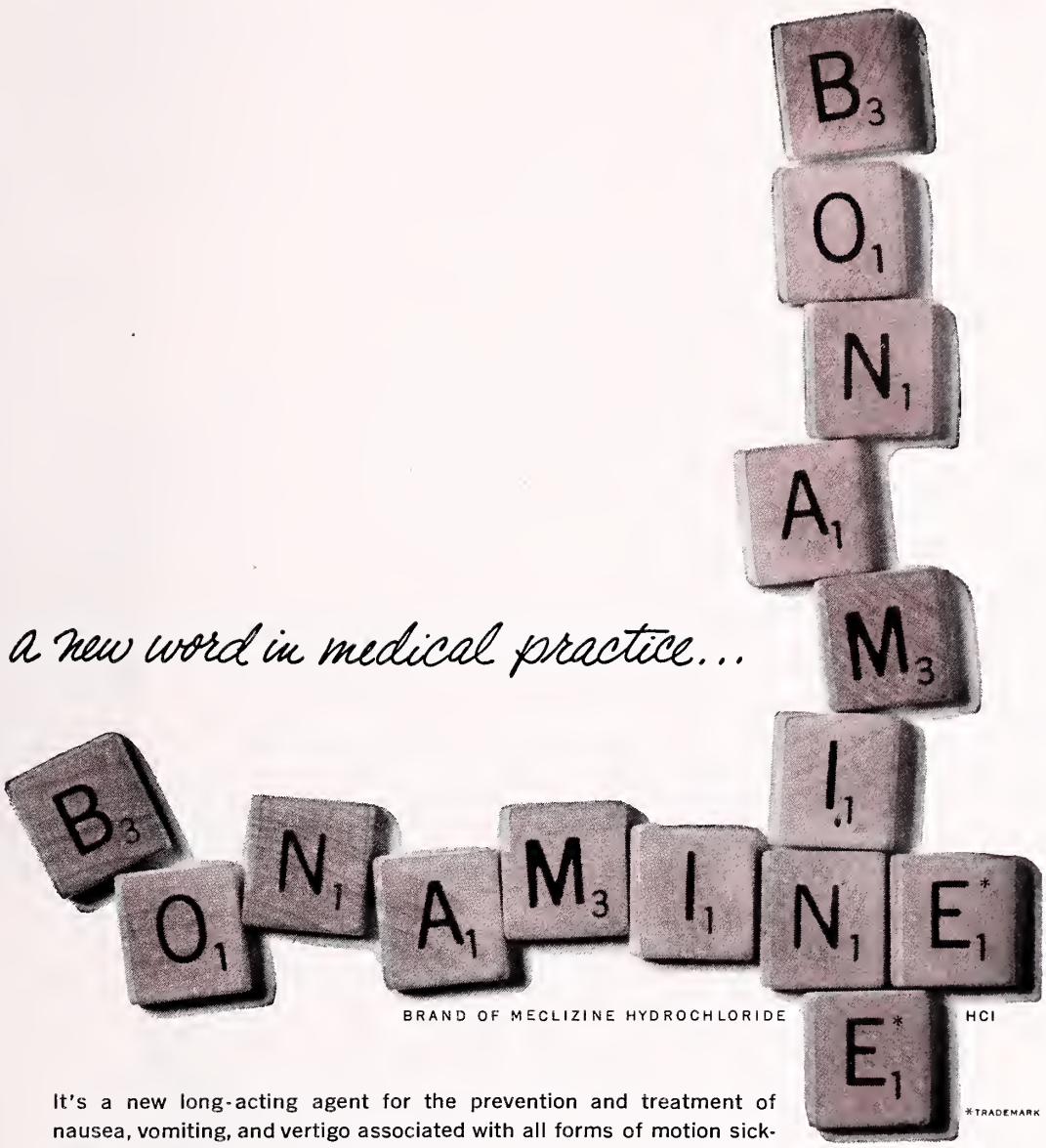
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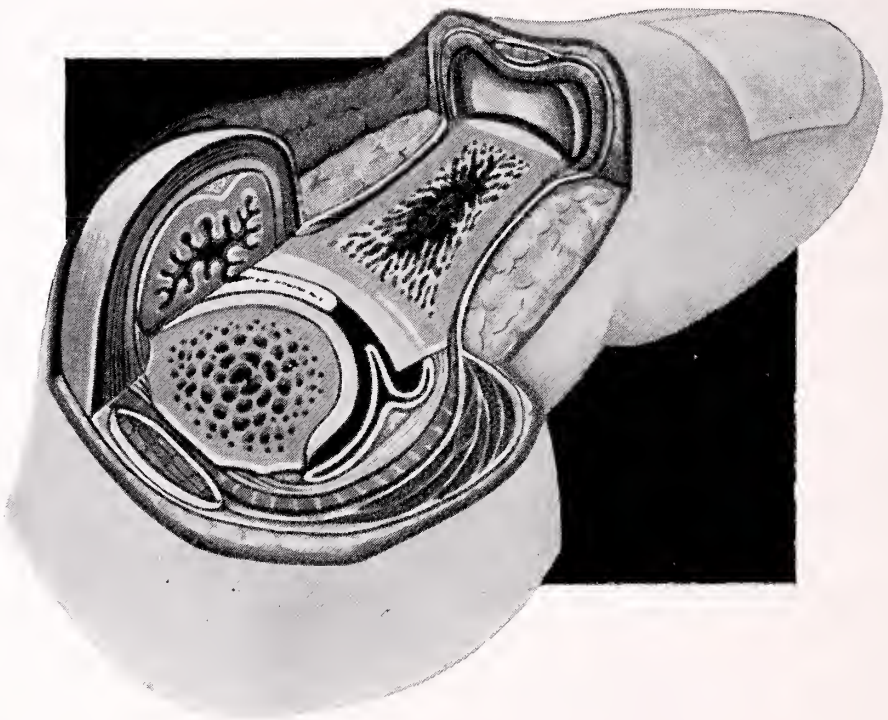
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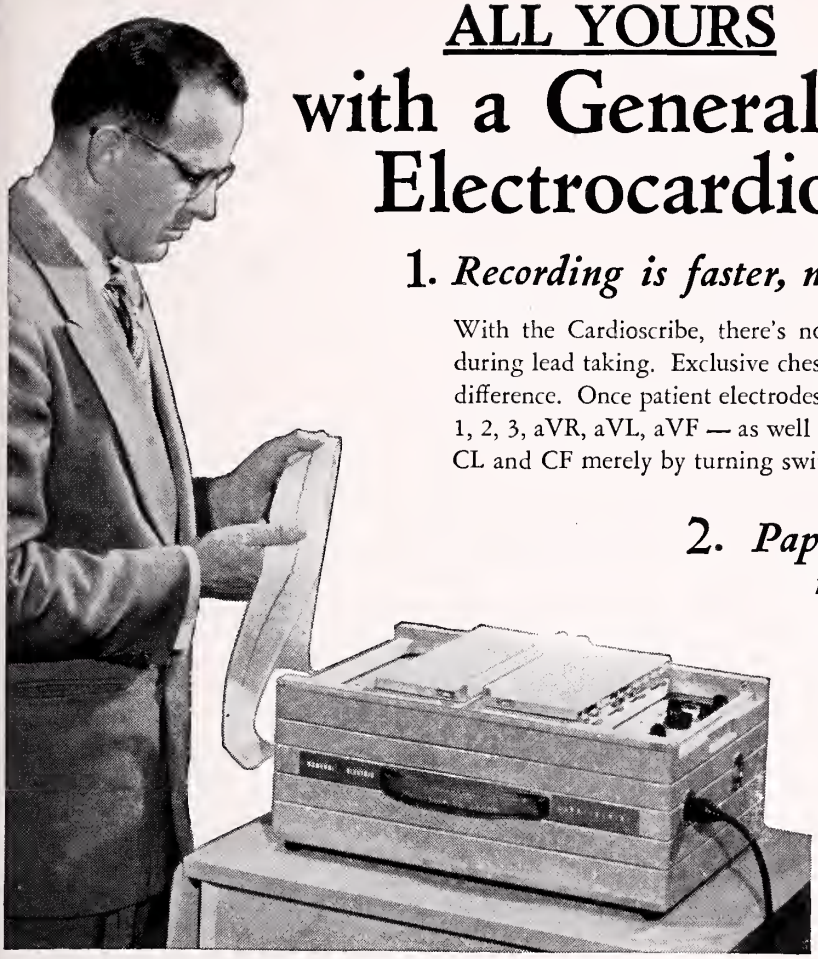
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*Bunim, J. J.: Research Activities in Rheumatic Diseases. Pub. Health Rep. 69:437, 1954.



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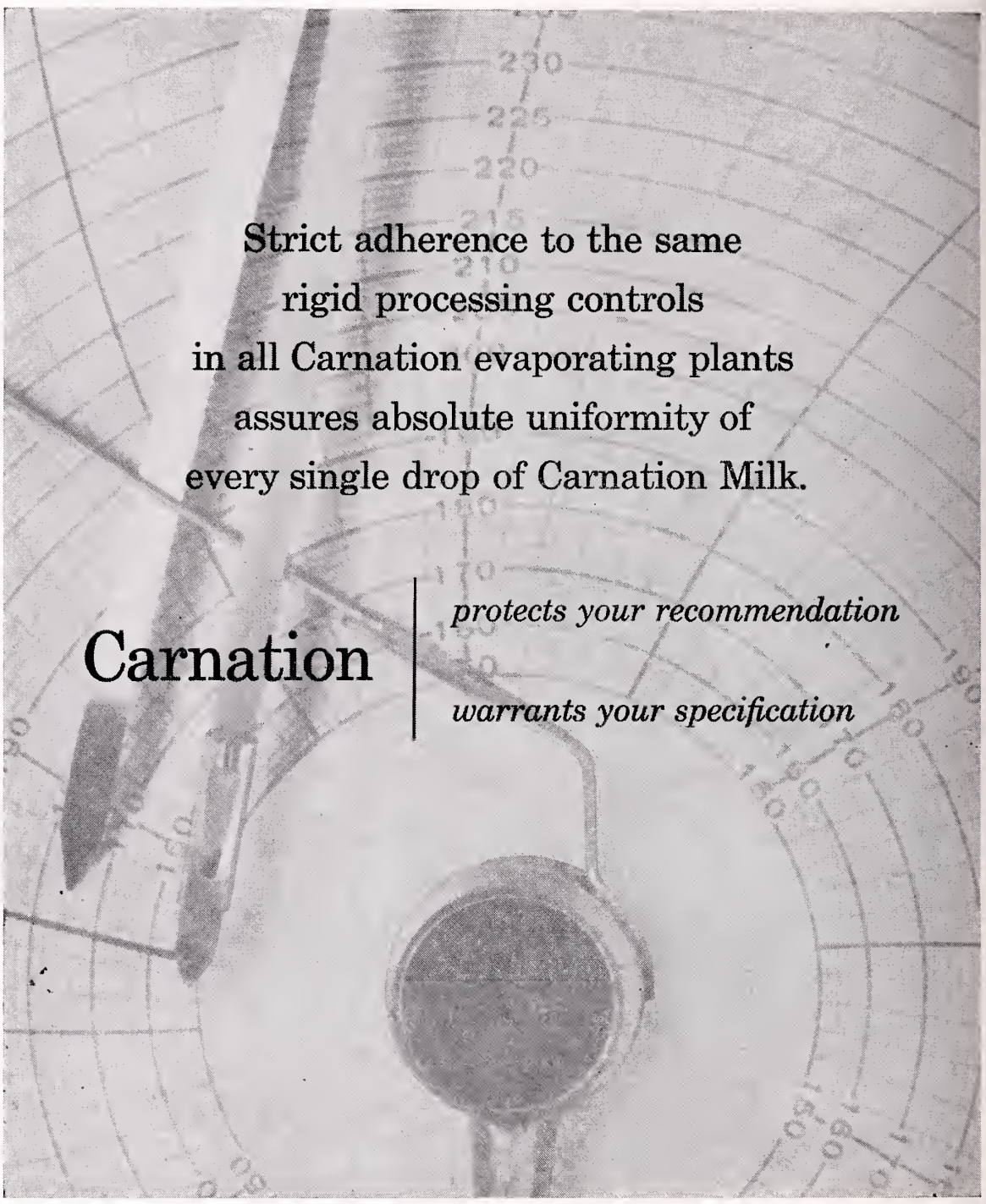
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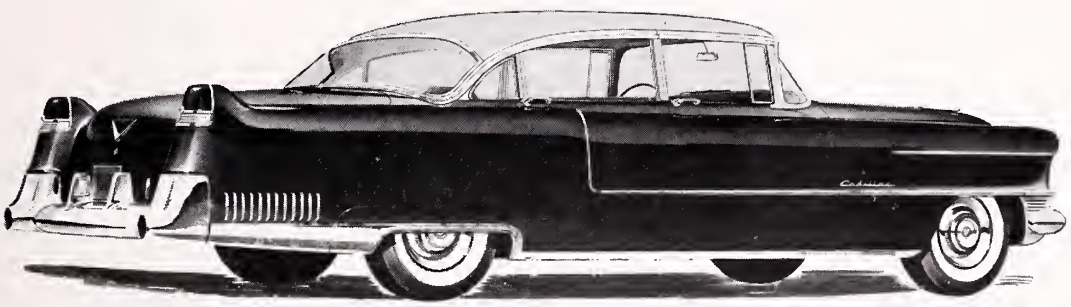


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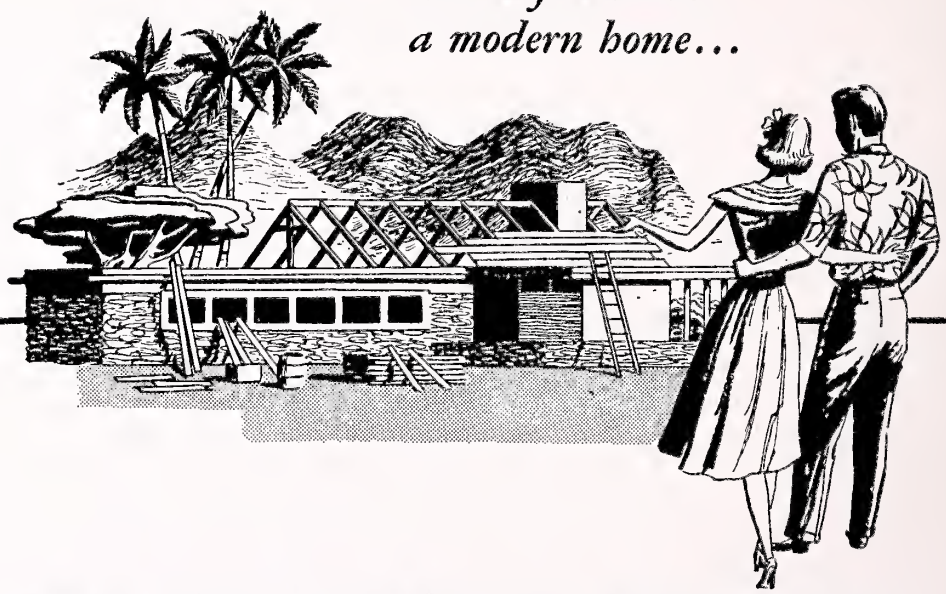
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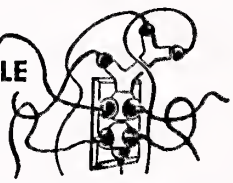
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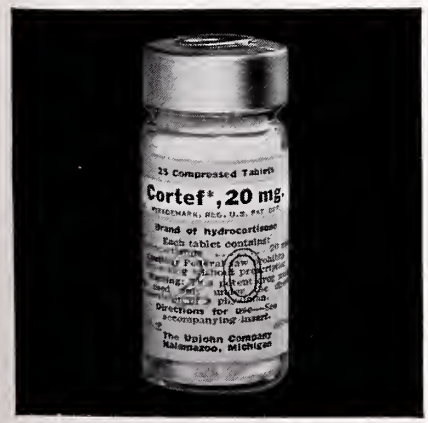
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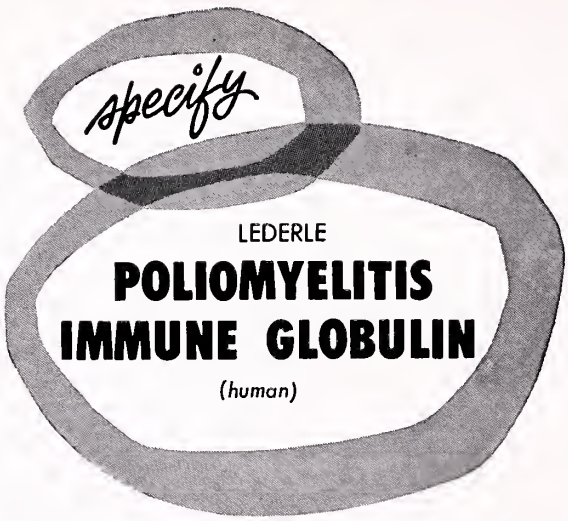
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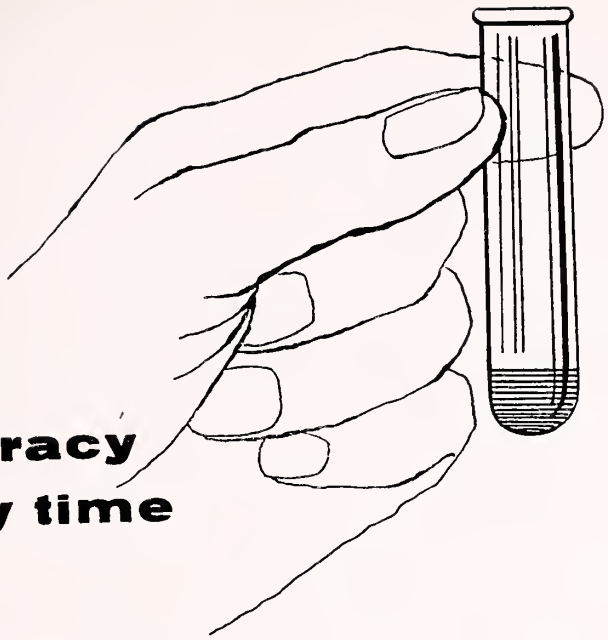
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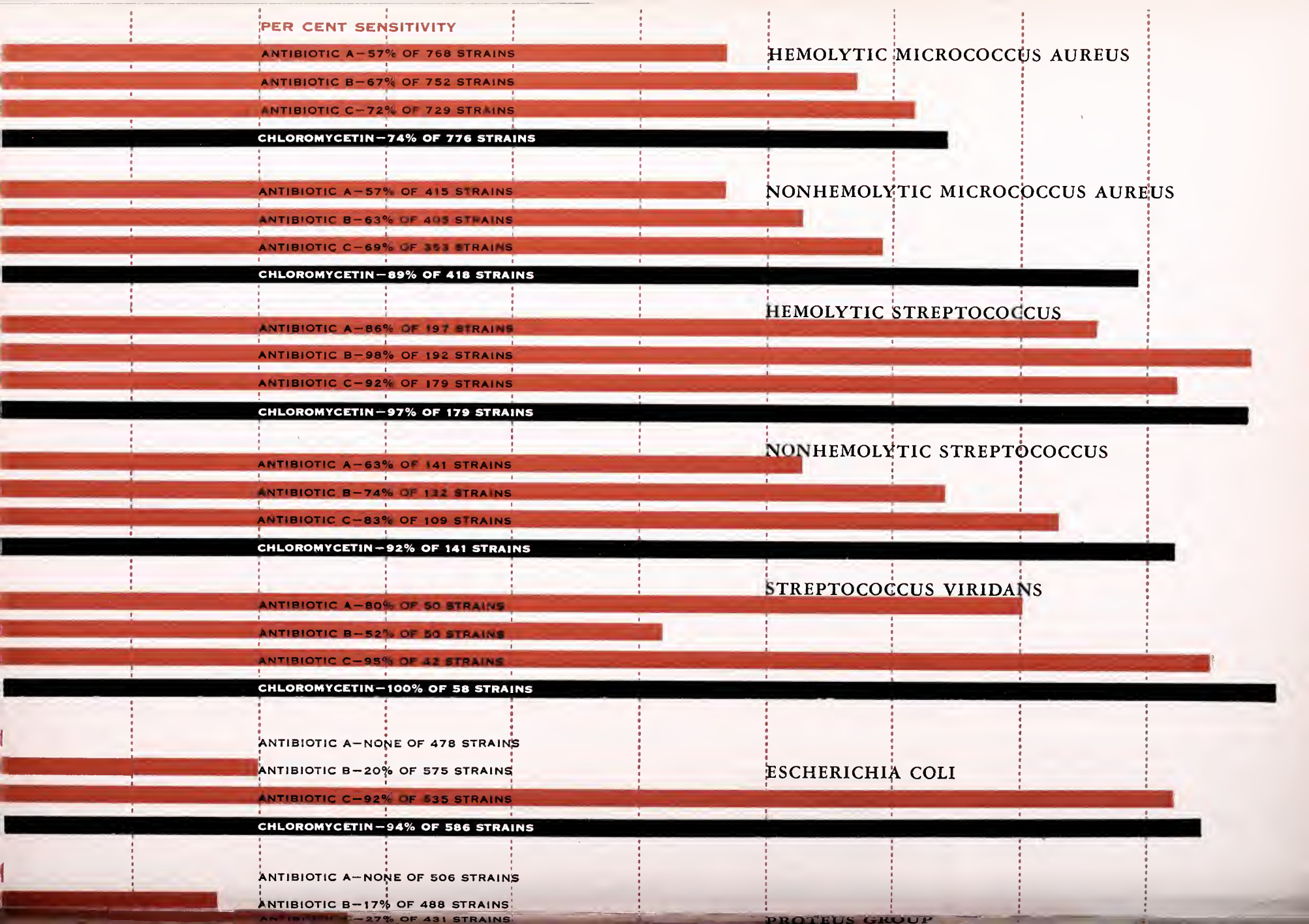
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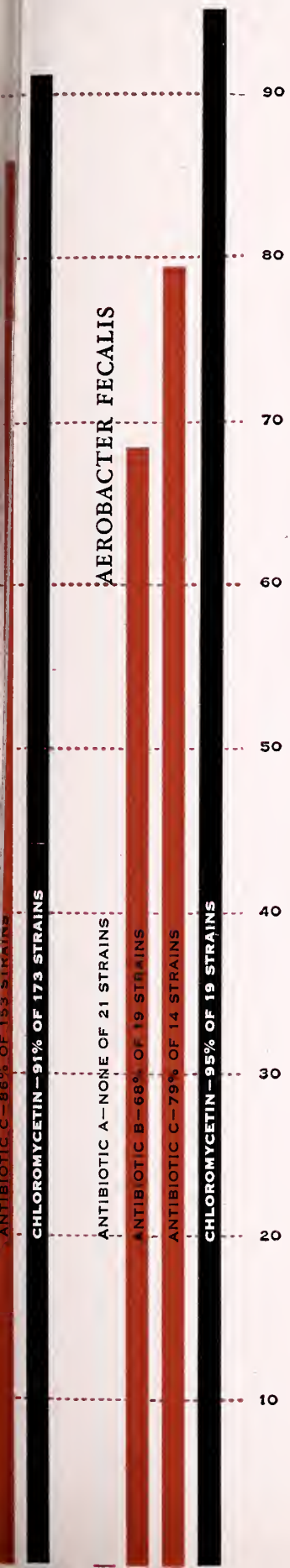
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ANTIBIOTIC C—83% OF 109 STRAINS
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STREPTOCOCCUS VIRIDANS
ANTIBIOTIC A—80% OF 50 STRAINS
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ANTIBIOTIC C—95% OF 42 STRAINS
CHLOROMYCETIN—100% OF 58 STRAINS
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ANTIBIOTIC A—NONE OF 478 STRAINS
ANTIBIOTIC B—20% OF 575 STRAINS
ANTIBIOTIC C—92% OF 535 STRAINS
CHLOROMYCETIN—94% OF 586 STRAINS
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Adapted from Altemeier, W. A.; Culbertson, W. R.; Sherman, R.; Cole, W.; Elstun, W., & Fultz, C. T.: *J.A.M.A.* 157:305 (Jan. 22) 1955.

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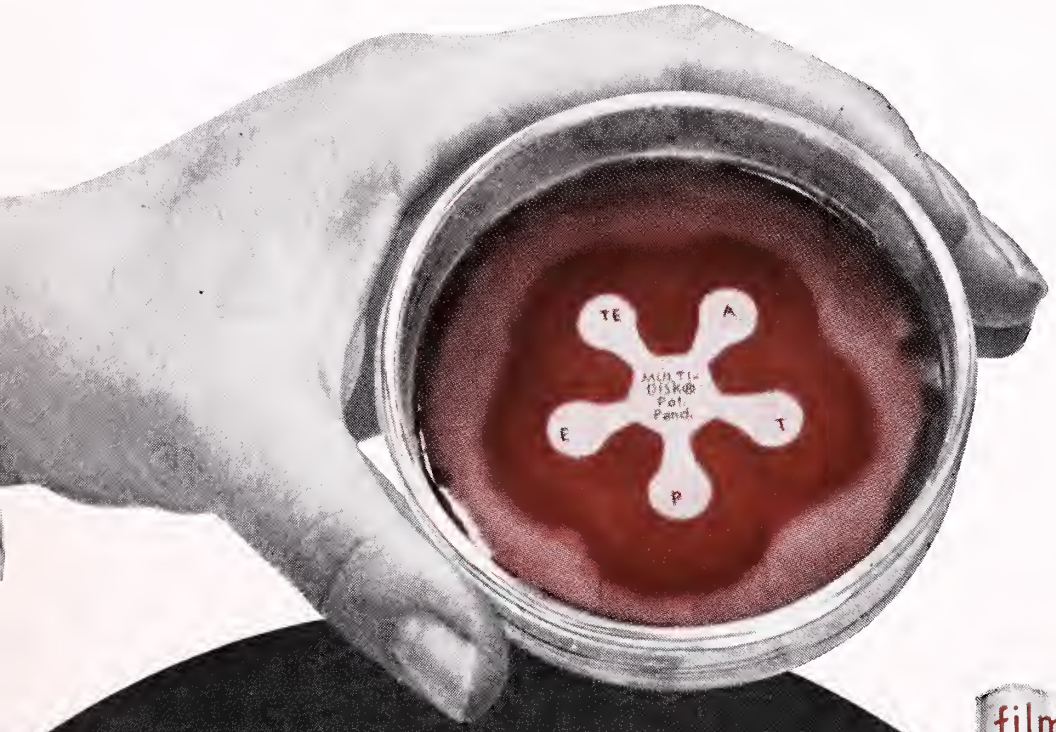
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PHOTOMICROGRAPHY SEES WHAT THE HAND CANNOT FEEL



D & G gut

Photomicrograph shows the smooth surface of D & G SURGICAL GUT, with practically no fraying or roughness. *Reason:* Carefully controlled slitting of plies plus uniform twisting provides a smooth, well-bonded strand. No need to grind it to size. Gentle polishing gave the matte finish. *Result:* the full natural strength of each gut ribbon (ply) is preserved; the strand is not frayed by grinding.

Another leading gut

Photomicrograph reveals rough, frayed surface of another leading brand of gut. This has been ground to size. Gut processed in this way appears very uniform in diameter to the naked eye. But the photomicroscope reveals serious imperfections which may cause fraying and loss of strength when the knot is tied.

see exhibit on next page

Photomicrographs (unretouched) by E. J. Thomas, Stamford Laboratory of the Research Division of the American Cyanamid Company, Stamford, Conn.

Method used: dark field, transmitted bright field illumination, 138 x. Material used: medium chromic gut, size 5-0.

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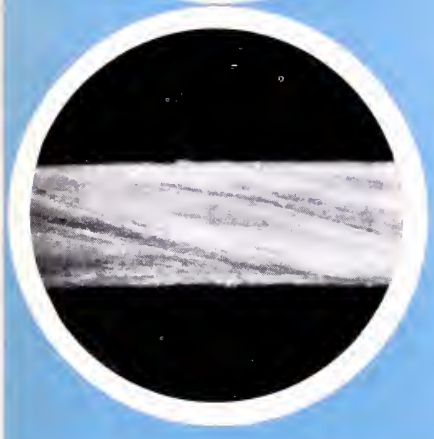
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Photomicrography shows why D & G gut is more flexible



D & G GUT

Firm, even cohesion of plies is apparent in this photomicrograph of a D & G SURGICAL GUT suture.
Reason: plies were twisted into a strand before suture was chromicized. Natural cohesive forces of moist untreated collagen firmly bond the plies together and hold the twist.
Result: under stress, plies of the suture hold together. The D & G gut is more flexible and knot strength is greater.



ANOTHER LEADING GUT

Photomicrograph detects separate and distinct plies in a strand of another leading brand of surgical gut. Here each ply was chromicized before they were twisted into suture strands. Such "ribbon chromicizing" hardens the surface of each ply, decreasing the natural bonding action, lowering the flexibility and tensile strength of the suture.

Photomicrographs (unretouched) by E. J. Thomas, Stamford Laboratory of the Research Division of the American Cyanamid Company, Stamford, Conn.

Method used: dark field, reflected illumination, focus on crest of surface, 38 x. Material used: medium chromic gut, size 00.

see exhibit on previous page

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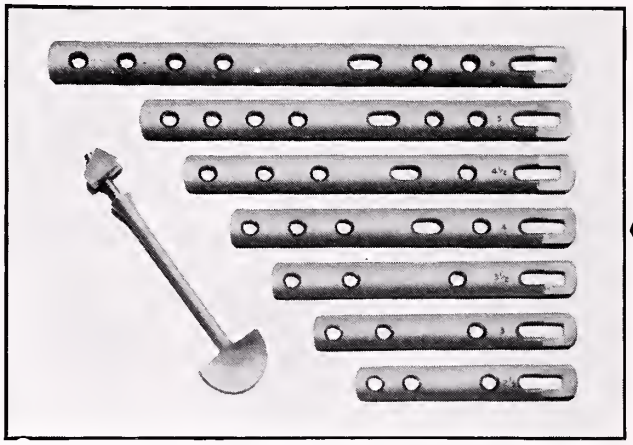
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6. Burrage, W. S., and Irwin, J. W.: *Med. Clin. North America*, 36:1269, Sept., 1952.

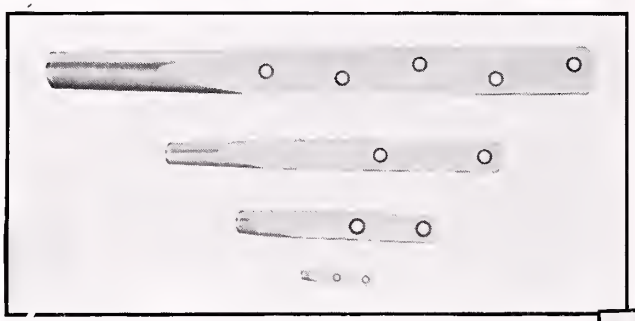
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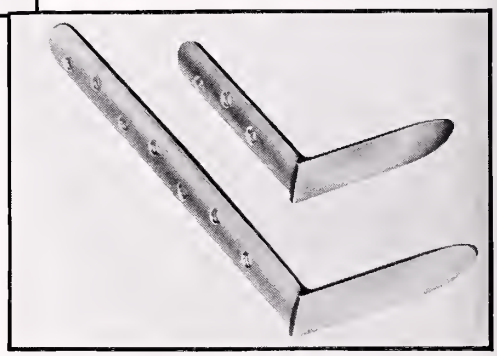
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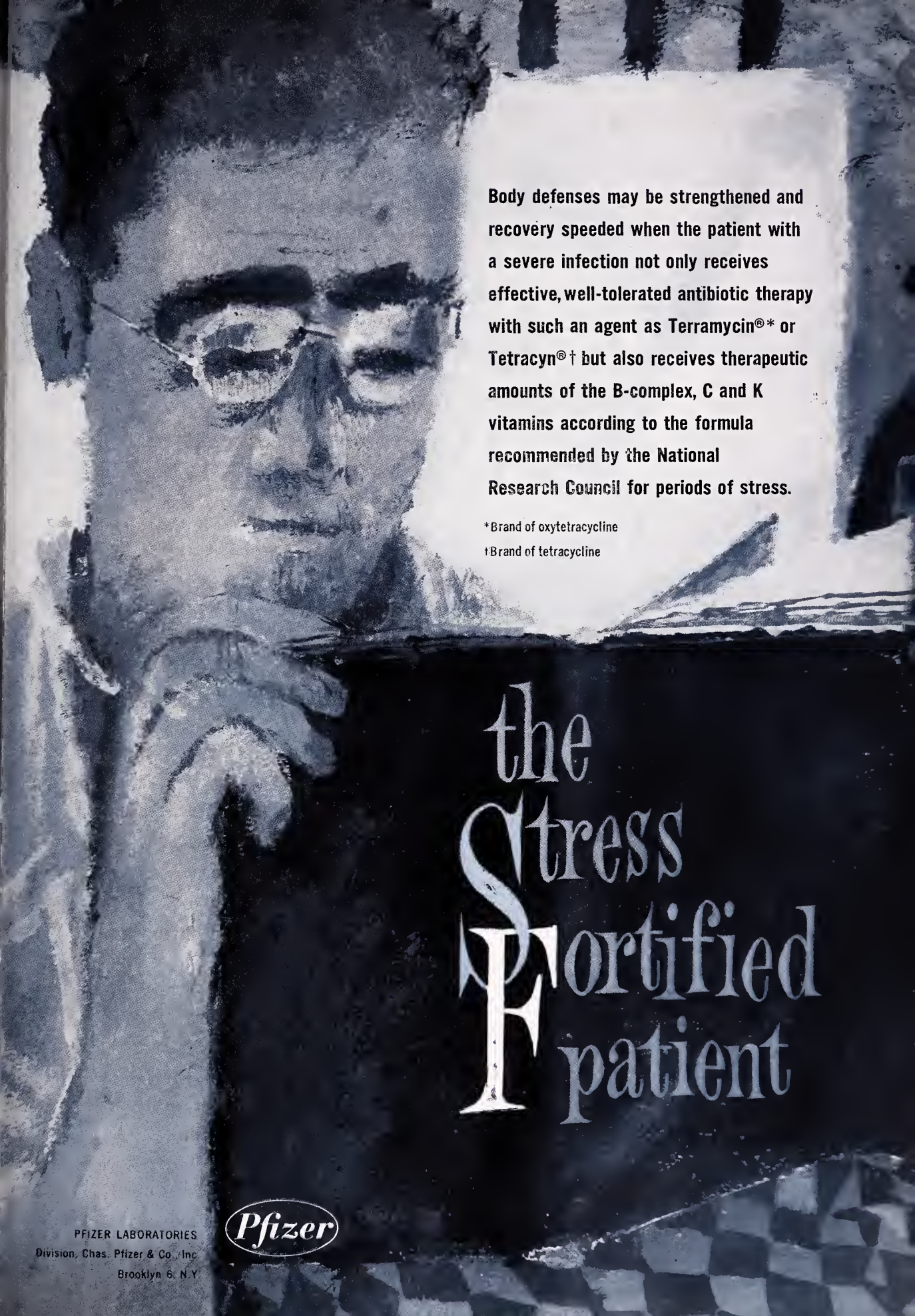
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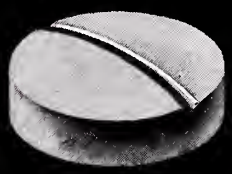
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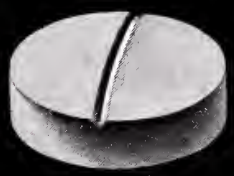
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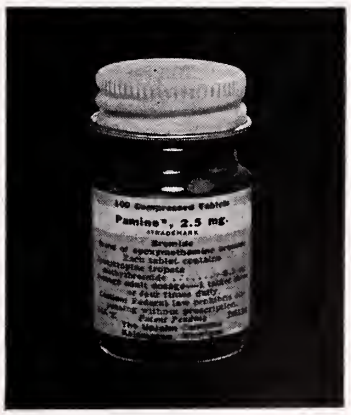
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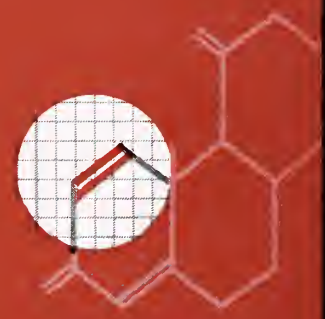
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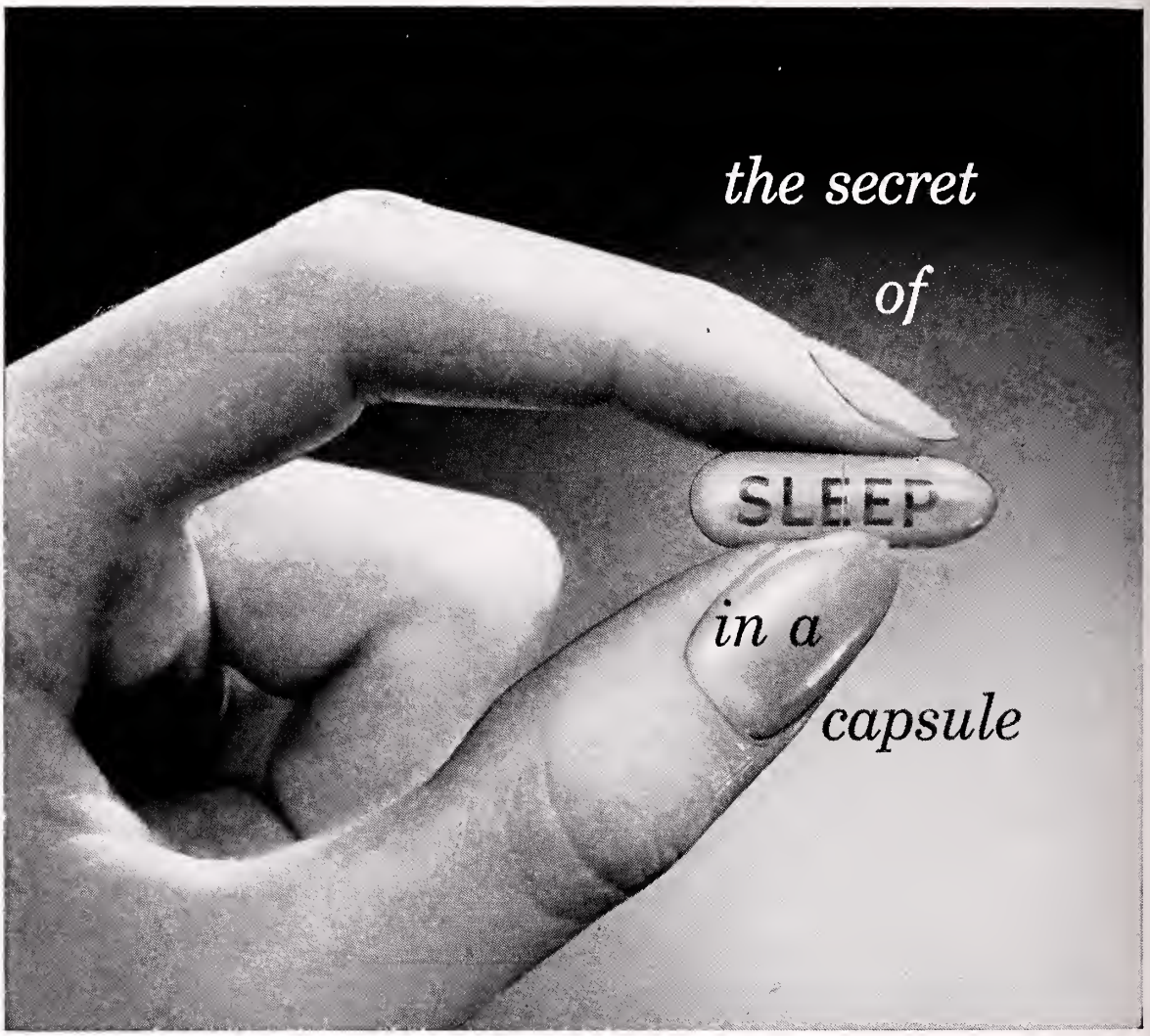
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THE SURGICAL TREATMENT OF PATENT DUCTUS ARTERIOSUS

Report of 14 Consecutive Cases

C. M. BURGESS, M.D., G. C. FREEMAN, M.D.,
J. W. CHERRY, M.D., AND A. S. HARTWELL, M.D., Honolulu, Hawaii

THE SURGICAL treatment of the patent ductus has been developed and technically perfected in the past fifteen years. The safety of the operation, when properly carried out by those familiar with the conditions found, is so well established that no one over 4 years of age and under 30 should be denied the unquestioned benefit of having the shunt closed. Recent developments in technique, notably the use of the Potts-Smith-Gibson clamp, as advocated by Conklin and Watkins,[1] make many authorities feel that any patent ductus at any age should be closed, even in the absence of symptoms of cardiac embarrassment.



DR. BURGESS

Although reports have been published by Fishman and Silverthorn[2] of two individuals living to 73 and 75 years with a patent ductus, the fact remains that these patients finally died as a direct result of the presence of the lesion. Certainly the adult who has cardiac embarrassment from the presence of the ductus faces a markedly decreased life span unless something is done. It is believed by the authors that careful technique and the use of the Potts-Smith-Gibson clamp will allow the operation to be performed with a mortality no greater than that of any major-risk procedure. This risk should be only a fraction of that accompanying the untreated condition itself. One must not forget the constant threat of bacterial endarteritis, which of course ends the lives of many patients with this anomaly. When we realize that the cardiovascular system can be restored to normal by division of the ductus, the indications for conservative treatment must be carefully scrutinized.

From the Departments of Surgery and Internal Medicine, Straub Clinic.

Received for publication February 21, 1955.

[1] Conklin, W. S. and Watkins, E., Jr.: Use of the Potts-Smith-Gibson Clamp for Division of Patent Ductus Arteriosus, J. Thoracic Surg. 19:361 (Mar.) 1950.

[2] Fishman, L. and Silverthorne, C. M.: Persistent Patent Ductus in the Aged, Am. Heart J. 41:762 (May) 1951.

Differential Diagnosis

The diagnosis of patent ductus arteriosus can be made with considerable accuracy on the basis of history, physical examination and fluoroscopic and electrocardiographic determinations in persons over the age of 4 years. The typical continuous roaring murmur with systolic accentuation in the second and third left interspaces, accompanied by a systolic thrill, is nearly always present. At times, the diastolic element may be difficult to hear; and in children under the age of 3 there may be a very faint murmur, or no murmur at all.

Certain conditions must be borne in mind when the above-described murmur is heard. A venous hum near the left clavicle may be confusing, but compression of the neck veins should largely obliterate this sound. An arteriovenous fistula in the mediastinum or pulmonary tissues, where there is a left-to-right shunt and therefore no cyanosis, may cause difficulties; but this condition is quite rare. Occasionally rheumatic aortic insufficiency and stenosis may have a murmur simulating a patent ductus, and of course an aortic septal defect may be indistinguishable clinically even after cardiac catheterization. Interatrial septal defect may at times also be confused with a patent ductus.

The presence of cyanosis or hyperhemoglobinemia, in the absence of dehydration, should make one hesitate to make a diagnosis of pure patent ductus.

Fluoroscopic examination, with a swallow of barium to determine the course of the esophagus, is extremely valuable. The presence of a prominent pulmonary conus, with some hilar congestion and a slightly prominent left ventricle, is very helpful, as is the finding of a widened pulse pressure. We feel that the vast majority of pure patent ductus arteriosus can be diagnosed accurately with the procedures outlined above, and that cardiac catheterization is not necessary.

Treatment

According to Taussig,[3] the ideal age for operation is between 4 and 6 years. Prior to the age of 4, the diagnosis simply cannot be made with any

[3] Taussig, H. B.: Clinical Progress, Diagnosis and Management of Common Malformations of the Heart, Circulation 6:930 (Dec.) 1952.

degree of certainty. Surgery is technically easier, and is carried out with a lower mortality, during the early years of childhood.

The anesthetic used on these 14 patients was intratracheal oxygen-ether, preceded by pentothal induction in the adults. This was satisfactory in all cases, and we agree with most writers that it is the anesthetic of choice. Gross[4] has given up cyclopropane as being too prone to cause cardiac arrhythmias and arrest.

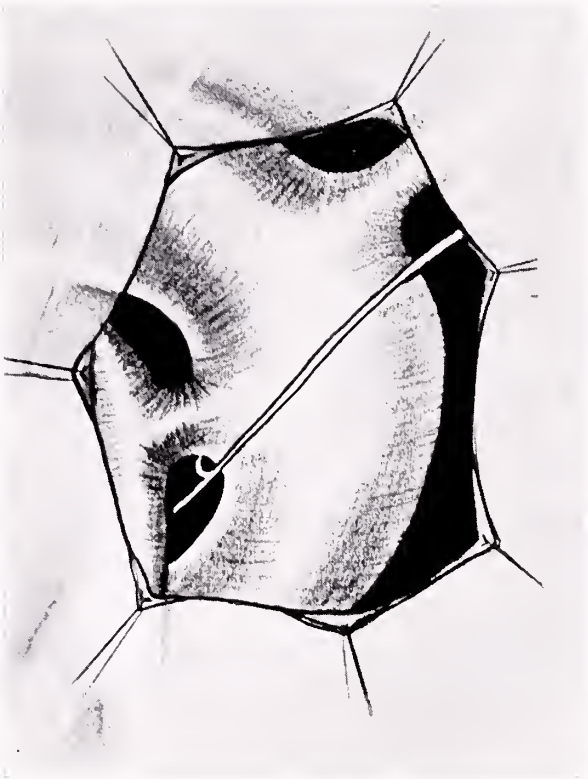


FIG. 1. Drawing showing the usual anatomy found in a typical case of patent ductus arteriosus. The vagus nerve with its recurrent laryngeal branch is a guide to the position of the ductus.

These cases have all been treated in much the same way as far as the actual technique of surgery is concerned. A curved incision was made underneath the left breast, cutting the pectoral muscles and reflecting the breast and these muscles upward. Often it had to be carried below the tip of the scapula to give adequate exposure for the application of the Potts-Smith-Gibson clamp, which was used routinely on all but the first two patients. The approach in all the children was through the bed of the third rib; in adults, the fourth rib was removed. They were all placed in the anterolateral position; that is, approximately 45 degrees from the vertical on the table. This was felt advantageous because it allowed maximum function of the usually compressed right lung.

After injection of the vagus nerve with 1 per cent novocaine, an incision was made overlying the aorta and the nerve with its recurrent branch visualized and retracted (Fig. 1). Care was used not to involve the phrenic nerve in the incision or in the retraction sutures.

Adequate mobilization of the aorta is necessary so that the Potts-Smith-Gibson clamp can be applied. In order to do this, it was always necessary to ligate one and occasionally as many as three of the upper intercostal vessels. However, this dissection was never difficult, and as mobilization of the aorta proceeded, it was remarkable how it facilitated the dissection of the ductus, especially in its posterior portion where it tends to be adherent to the bronchus.

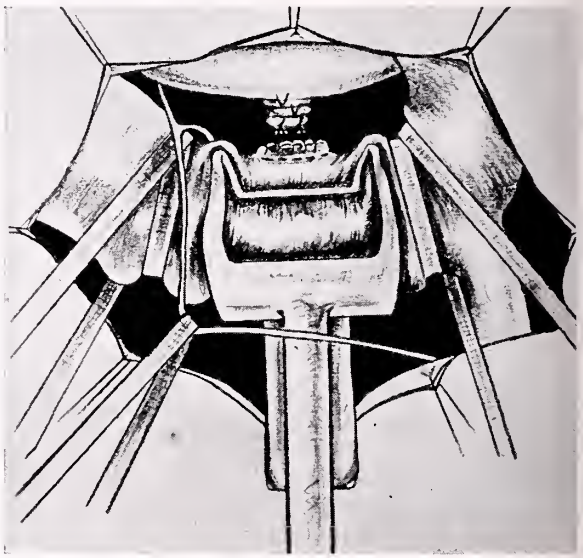


FIG. 2. Drawing showing the Potts-Smith-Gibson clamp in place occluding the ductus, which has been closed with a continuous everting mattress suture and a reinforcing over-and-over stitch. Small penrose drains are shown looped around the aorta proximal and distal to the ductus. Double ligatures are shown on the pulmonary artery side of the ductus. The vagus nerve and its recurrent branch are carefully handled to prevent injury.

The near disaster that followed excessive hemorrhage in the second case has convinced us that the use of the Potts-Smith-Gibson clamp is invaluable insurance which the operator should never be without, especially on adults with attenuated and dilated aortic walls. The illustration (Fig. 1) shows the anatomical features in a typical case. Figure 2 shows the treatment of the pulmonary artery and the aortic side of the ductus. In each

[4] Gross, R. E. and Longino, L. A.: The Patent Ductus Arteriosus, Circulation 3:125 (Jan.) 1951.

case, the patent ductus was ligated and divided in the manner described by Conklin and Watkins.

The use of the clamp to occlude the ductus, while the general condition of the patient is observed to rule out any other congenital lesion, is of great value. Five or six minutes, while the lungs are being re-expanded, are allowed for this procedure.

A thoracotomy tube, consisting of a large Foley catheter, was routinely placed in the dependent portion of the chest prior to closing the incision. This was attached to a water seal.

Postoperatively, these patients have had no significant complications. One patient developed a subcutaneous hematoma in the incision; none of them developed pleural effusion that persisted beyond the first week; and none required aspiration. The early cases were all placed in an oxygen tent following surgery, but in the latter ones, this expensive procedure was found to be unnecessary.

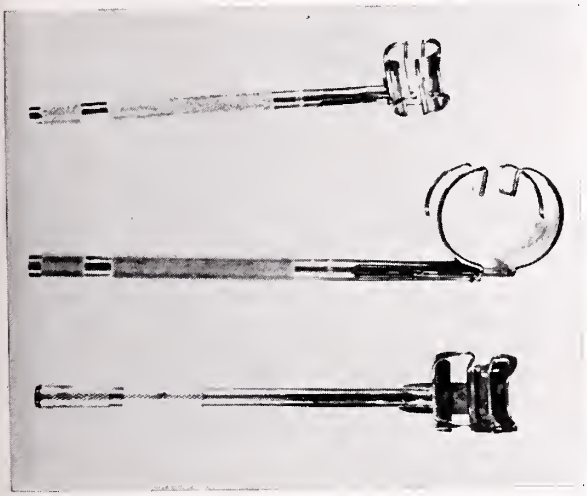


FIG. 3. Three sizes of the Potts-Smith-Gibson clamp, necessary to properly fit the different sizes of aorta in patients of different ages, and the varying degrees of aortic dilatation found.

Case Report

Mrs. E.O., a 32 year old Japanese woman, was operated upon on January 9, 1953, for a patent ductus with marked cardiac enlargement. When the area of the ductus was exposed, a pronounced dilatation of the aorta distal to the shunt was noted. During the dissection to free the ductus, a rent occurred in the dilated portion of the aorta behind and immediately adjacent to the ductus and an exsanguinating hemorrhage resulted with cardiac arrest.

The aorta was clamped distal to the left subclavian artery; cardiac massage was immediately started and rapid replacement of blood was carried out. Mobilizing and rotating the aorta caused the tear to extend further, but no further bleeding occurred, because of the proximal clamp. The rent on the posterior wall, as well as the aortic opening of the ductus, was closed with vascular sutures and the pulmonary end of the ductus was ligated.

While the ductal openings and the aortic tear were being repaired, effective blood pressure was maintained by massage of the heart. There was no contraction of the myocardium for a period of forty-five minutes, but after that time a few feeble contractions were noted, and myocardial tone returned. At the end of one hour and fifteen minutes, a regular cardiac rate of 100 was established, with forceful, vigorous pulsations.

In spite of the long period of arrest, no cerebral damage resulted. The patient regained consciousness a few hours after surgery, was oriented, and recognized members of the family as well as her physicians. Though one would expect serious sequelae from the one hour and fifteen minutes during which the kidneys were deprived of their blood supply, the patient passed 1700 cc. of urine in the first twenty-four hours and she was able to concentrate satisfactorily. Almost complete flaccid paralysis of both lower extremities lasted about three weeks, after which time strength and active control of the legs slowly returned.

Since the operation two years ago, the patient has had no cerebral sequelae from her cardiac arrest, but she has not completely regained the use of all muscle groups in the lower extremities. She is able to walk without assistance, but with an alteration of her gait and rather marked atrophy of her calves, and the legs tire readily.

Discussion

Table 1 gives pertinent data regarding the 15 patients we have operated upon for patent ductus arteriosus. The first 14 revealed the typical operative findings, and the ductus was successfully divided and closed. The pulmonary artery side was ligated and usually transfixed; in all cases the aortic defect was closed with two rows of continuous suture reinforced with interrupted sutures where needed. The last case, T.I., was operated upon with a preoperative diagnosis of probable patent ductus arteriosus, though there was some doubt, due to the atypical character of the murmur. The finding of an aortic septal defect was not unexpected, therefore, and this diagnosis could not have been made in any other way with any degree of certainty.

The table shows that of the 14 successful cases, 7 were 6 years of age or younger. The remaining 7 ranged from 11 to 34 years of age. As in most series, there was a preponderance of females over males of 11 to 3. The series is too small to permit any conclusions regarding the racial incidence of the disease, but it is interesting to note that 5 of the patients were Japanese, 4 Filipino, 3 part Hawaiian, and only 1 Caucasian. Symptoms were either absent or minimal, only the 3 oldest patients showing significant restriction of activity by dyspnea on exertion. Three of the young children showed significant retardation of development.

The physical findings were not unusual in most cases. All but 4 cases had the classical murmur. All patients had an increased pulse pressure. Some degree of cardiac enlargement was present in all

TABLE 1.—*Fifteen consecutive cases operated upon for persistent patent ductus arteriosus by the authors, with relevant signs and symptoms and results obtained.*

	CASE	AGE	SEX	RACIAL EXTRACTION	SYMPTOMS	MURMUR	BP	CARDIAC ENLARGEMENT	POST-OP. RESULT
1	G.H.	4	F	Japanese	None	Classical	100/60	Slight	No murmur
2	C.A.	3	F	Part Haw'n	Retarded development	Classical	100/0	Progressive gallop rhythm	No murmur
3	Y.A.	11	F	Filipino	None	Classical	100/40	Moderate	No murmur
4	C.P.	5	F	Filipino	None	Classical	100/40	Moderate	No murmur
5	D.N.	6	M	Part Haw'n	Asthma	Classical	90/25	Slight	No murmur
6	S.S.	5	F	Japanese	Retarded development	Pulmonary systolic & diastolic	110/60	None	No murmur
7	D.U.	2½	M	Filipino	Retarded development	Classical	110/40	Progressive	No murmur
8	B.J.V.	6	F	Caucasian	None	Pulmonary systolic gr. III faint diastolic	100/40	Slight	Grade II pulmonary systolic murmur
9	P.A.	12	F	Part Haw'n	None	Classical	90/30	Moderate	No murmur
10	R.A.	17	F	Japanese	Asthma	Classical	110/60	Moderate	No murmur
11	A.R.	20	M	Filipino	None	Pulmonary systolic with thrill	100/50	None	No murmur
12	E.O.	24	F	Japanese	Dyspnea on exertion	Classical plus apical systolic	120/10	None	Grade I pulmonary systolic murmur
13	E.O.	32	F	Japanese	Dyspnea on exertion	Classical	105/10	Progressive	Pulmonary grade I systolic murmur
14	H.Y.	34	F	Chinese	Dyspnea on exertion	Classical	110/50	Moderate	No murmur
15	G.I.	25	M	Japanese	Decompensation	Continuous roaring murmur	100/0	Progressive	Same as before exploration

but three of the patients and was progressive in the two youngest, C.A. and D.U., who were operated upon as semi-emergencies because of this. No murmurs were audible after surgery in 11 of the 14 successful cases. Three showed a pulmonary systolic murmur of Grade I or II intensity but in none was there a diastolic murmur present.

In these first 14 cases there were no deaths, and no postoperative complications with the exception of E.O. whose detailed case history has been given. The last case, G.I., whose septal defect was not amenable to correction, has a guarded prognosis. One patient, D.U., age 2½ years, was found to have a coarctation of the aorta of moderate degree in addition to the patent ductus arteriosus. There was no evidence of impairment of the circulation by the coarctation and no attempt was made to correct it. It is possible that such will be necessary at a later date.

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Summary

Fourteen cases of patent ductus arteriosus operated upon without a fatality have been presented. All were treated by ligation and division of the ductus.

The importance of the safety factor provided by the Potts-Smith-Gibson clamp has been discussed.

A detailed case report of one patient whose operation was complicated by excessive hemorrhage is given in detail. No cerebral or renal damage followed a prolonged period of cardiac massage and only slight permanent cord damage resulted from complete occlusion of the aorta for over one hour.

Addendum

Since the paper went to press two more cases have been successfully operated upon: a 16 year old Filipino girl with an enlarged heart and a short ductus (2 cm.), and a 4 year old part-Hawaiian boy with a small ductus.

THE RECOGNITION OF TINY PULMONARY DENSITIES

GEORGE W. HENRY, M.D., Honolulu

IN RECENT years it has become uncommon to see x-rays of a classic "lobar pneumonia." The great majority are either prevented or aborted during their inception by the current free use of antibiotics. Radiographic examination of these cases frequently will show no more than small segments or patches of infiltration. It is common in these cases to see a normal appearing chest or changes which are so small that they blend with the normal. In interpreting these films, the same observer will occasionally identify a density on one day and not the next, examining the same films. It often is not feasible to differentiate these mild or questionable changes from the normal vascular pattern. Some lump these mild, minimal, questionable changes, and normal variations under the stock phrase "exaggerated bronchovascular pattern." Although this latter phrase may be specific to certain individuals, it has become rather meaningless. Some physicians use this phrase to mean a normal variation; others as a quibbling phrase; and others mean a definite pneumonic process. A phrase with such multiple meanings is best discarded or qualified.



DR. HENRY

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There are a number of secondary signs available to assist in the interpretation of the scanty or indefinite radiographic densities in the chest film. These have all been previously described in the early radiographic literature, but do not seem to be generally known. Their application in questionable cases helps to identify lung parenchyma changes that were uncertain, when judged on the basis of the density of the lesion alone.

One of the best of these secondary signs is the visible bronchial tree, which was most recently redescribed by Fleischner[1] in 1948. This is best explained by illustration. In Figure 1 A the water filled straws in an empty paper cup represent the normal pulmonary arterial tree. Between 95 and 97 per cent of the demonstrable shadows on normal chest films are produced by vessels, with only an insignificant amount contributed by the bronchi. The latter are practically invisible in the norm.

Figure 1 B shows air filled straws suspended in a cup of water, which are apparent as radio-

[1] Fleischner, F. G.: The Visible Bronchial Tree, Radiology 50:184 (Feb.) 1948.

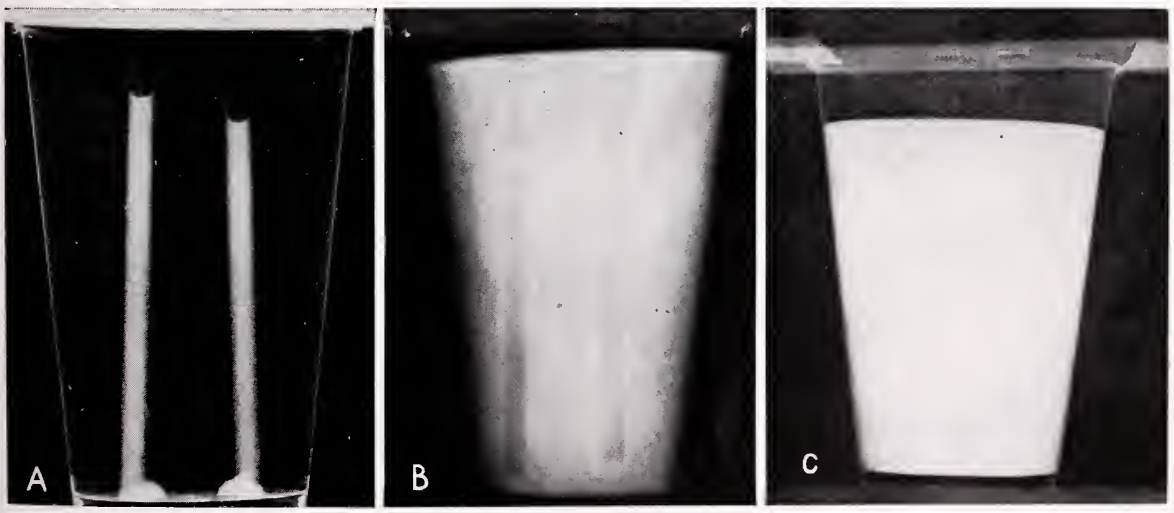


FIG. 1—Diagrammatic demonstration of the "visible bronchial tree." A.—The water filled straws in an empty cup represent pulmonary vessels in a normal chest. They produce white linear densities. B.—Air filled straws in a cup of water represent bronchi containing air with a surrounding pneumonia. They produce dark or radiolucent linear shadows. Their visibility indicates that the bronchi are patent and contain air, and that the air in the surrounding lung parenchyma is absent. C.—Water filled straws in a cup of water showing obliteration or non-visibility of the pulmonary vessels when the normal surrounding air is lost.



FIG. 2—Classic, easily seen visible bronchial tree. Detail of the contiguous vessel shadows is lost. A viral pneumonitis.

lucent lines with parallel borders. These are representative of air-conditioning bronchi in the midst of surrounding infiltration in the lungs. It is only when such a situation exists that bronchi are identifiable; that is, excluding special contrast studies.

Figure 1 C shows the vascular pattern itself to be completely obliterated by the surrounding water in a cup, as the density of the surrounding material and the vessel are the same. This sign or finding of a visible bronchial tree is pathognomonic of air replacement. If sought for, it frequently can be seen, and is of immense help. If the densities themselves are so vague as to be questioned, the visible tree will establish that a pathological process exists with certainty (Fig. 2). In identifying a visible bronchial tree, one must be cautious and not be misled by radiolucent patches caught between overlying vessels. With a little practice such errors are easily avoided, as the sides of these shadows are not parallel, while the visible bronchial tree invariably has parallel borders, even though the bronchus itself may be S shaped or curved. The value is also apparent in discovering lesions through or behind the heart shadow, below the diaphragm, or when there is a small amount of pleural fluid or thickening present. The visible tree can be identified through the overlying shadows.

An additional sign of equal value is loss of the heart or diaphragmatic border shadows. Normally the cardiac borders and diaphragmatic shadows are sharply defined, easily seen, curved lines. If the air in the contiguous lung parenchyma has been replaced by a soft tissue density such as a pneumonitis, the contrast will be decreased, and the sharp border is lost. The loss of these sharp borders indicates the presence of a contiguous density, whether it can be seen otherwise or not. This point

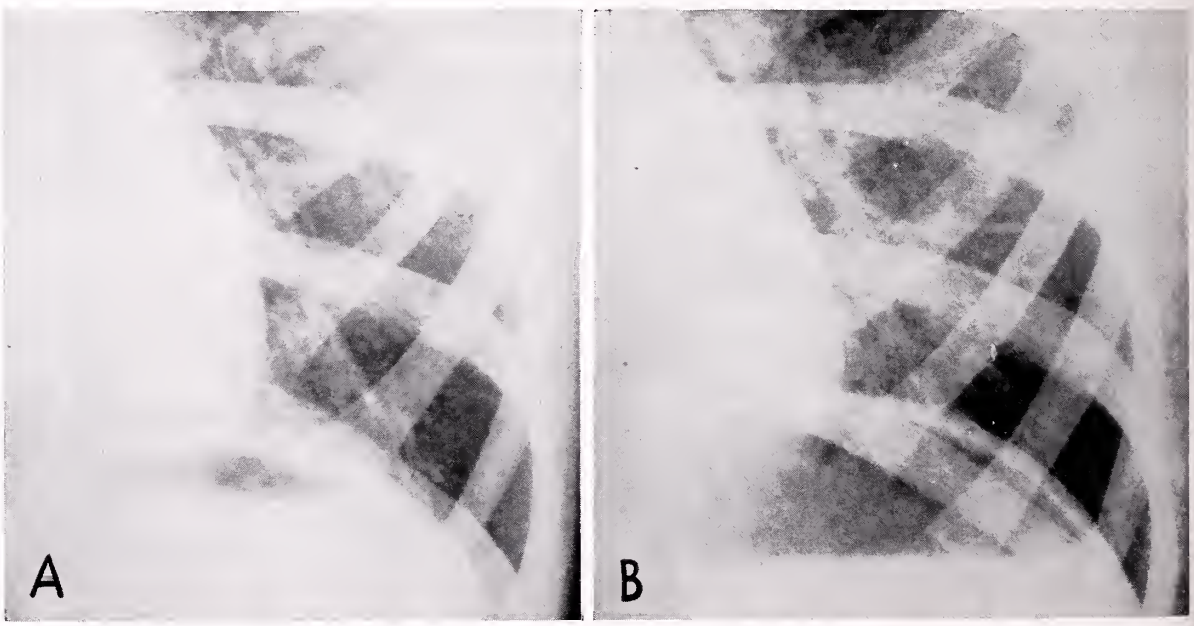


FIG. 3A—A viral pneumonitis has produced a small wedge shaped density near the apex of the heart. The vascular shadows are coarse, hazy, and clubbed. The shadow of the mid-portion of the left hemi-diaphragm is obliterated. On the original films the cardiac shadow had an irregular or mottled appearance. B—With resolution of the pneumonic process six days later the sharp diaphragmatic shadow has returned.

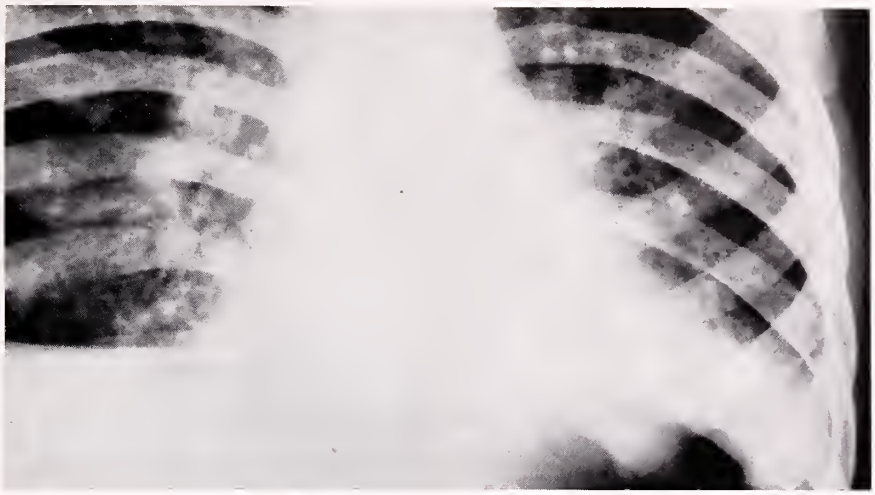


FIG. 4—Gross pneumonic infiltration in the left lower lobe obliterating the left hemi-diaphragmatic shadow but not the left heart border. The latter can still be seen through the density, as the infiltration is behind the heart and has not replaced the air along the left heart border. The right heart border is obliterated due to consolidation in the right middle lobe. If this were the only process present, it could easily be overlooked, if it were not for the absence of the right heart border.

has been particularly well stressed in the literature in reference to the right middle lobe, which obliterates the right heart border on the PA film. It is equally significant along most of the other cardiac and diaphragm borders (Figs. 3 and 4). It may be produced by any type of lesion in the lung parenchyma itself as a pneumonia, atelectasis, neoplasm, or by any pleural-space-occupying material, such as fluid or old pleural thickening. Unfortunately the latter is not infrequent and these pleural diaphragmatic adhesions produce this same picture. On the basis of the angled character, the latter can often be suspected, but serial films may be required to make a certain differential.

A third point is the appearance of the cardiac shadow. If the film is of adequate density, some detail can be seen through the heart, and in a normal individual it is uniform. When the heart shadow is mottled or irregular in nature, there must be replacement or displacement of the air-containing tissues in front of or behind the heart. Failing to look through the heart shadow is a common error. Unless one forces the eye to scrutinize this point routinely, significant lesions are overlooked.

The fourth group of signs is perhaps less certain, but much the more common. Exudate or inflammatory changes appearing about the pulmonary vessels replace the surrounding air. As a result the borders of these vessels lose their sharp contrast and change their character in several ways. The vessels become fuzzy, with shaggy borders; irregular clubbed shadows appear; the normal tapering arborizing pattern is lost, or the vessels may become indistinct, and difficult to identify (Fig. 5). The picture is not unlike that which is produced by motion of the subject during the exposure of the film. A pencil point can no longer be placed at the edge of the individual vessels, as these edges are no longer identifiable with that much certainty.

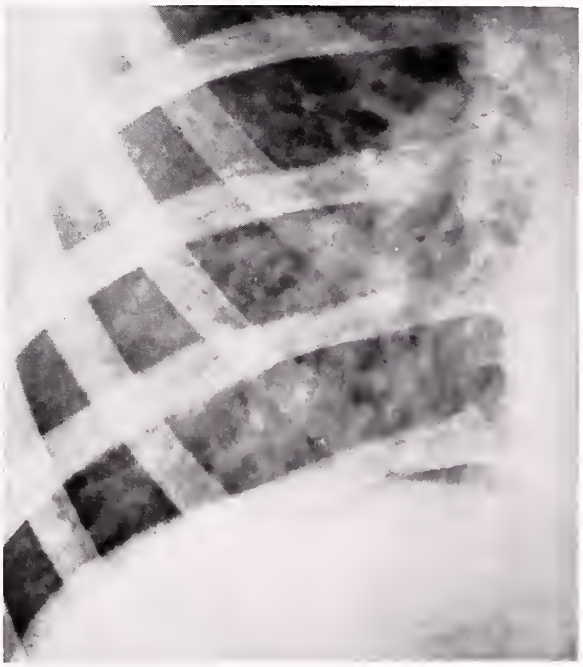


FIG. 5—A segmental pneumonitis with minimal parenchymal densities. The vascular shadows have lost their sharp edges and individual identity. In the center of this area the vessels are not visible, lost in a blur. More peripherally the vessels are shaggy, irregular, and clubbed shaped. A visible bronchial tree is present, though not clearly reproduced.

A reticular pattern may appear, the result of many smaller densities superimposed upon the smaller vascular shadows. When using these latter signs, one must first ascertain with certainty that the radiograph is of optimum quality. There must be no respiratory motion, and the technique requires a short exposure time and adequate penetration or kilovoltage. In a very squat individual or in any person with an elevated diaphragm, these fine changes cannot be applied to the basal segments, as there is insufficient air—in comparison to the number of vessels present—to make the changes applicable. Perhaps the most difficult task when using these signs is to ascertain whether the film is adequate or whether the patient's habitus permits its use.

A fifth sign is applicable primarily to the infant or young child. In these uncooperative individuals a chest film in full inspiration can rarely be attained. If two or more films in full inspiration are secured at the same sitting, it is pathognomonic of significant pulmonary or bronchial disease. This is classically seen in capillary bronchiolitis, but may also be demonstrable in other entities such as bronchopneumonia or the alveolar hyaline membrane syndrome.

These variable signs are indicative of some abnormality being present. They do not point to the underlying etiology, but may be produced by inflammatory changes of any type, neoplasm, atelectasis or even infarcts. Their value lies in determining whether an abnormality is present or not.

Summary

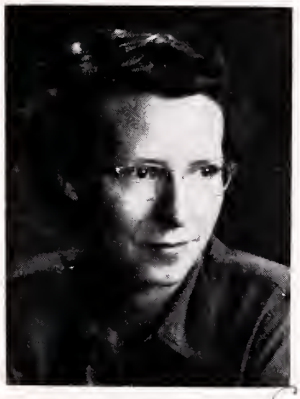
Small indistinct or questionable pneumonic densities may at times be differentiated from the normal vascular pattern in chest radiographs by the use of several secondary signs. The most certain or pathognomonic is the visible bronchial tree. Other signs that are helpful include loss of the sharp borders of the heart or diaphragm, irregular or non-uniform density to the heart shadow, and blurred, indistinct, shaggy and fuzzy vessels. Emphysema is also a good cue in infants or uncooperative children to indicate significant and usually important respiratory disease.

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THE USE OF PROPHYLACTIC DRUGS IN RHEUMATIC CHILDREN

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THE FIRST two years of the Rheumatic Fever Program at Children's Hospital were reviewed in 1951.[1] It was felt that the present status of the rheumatic fever program would be of interest particularly in regard to the effects of the administration of prophylactic drugs. One of the characteristic features about rheumatic fever is its tendency to recur. Numerous investigators have pointed out the likelihood of recurrences in children before the age of puberty,[2] and the particular danger of the first year after a rheumatic attack as far as recurrences are concerned.[3] The fact that recurrent attacks of rheumatic fever can be prevented when one of the sulfa drugs or penicillin is administered to rheumatic children is now well established. The methods of administration of prophylactic drugs in the prevention of rheumatic fever, including recommended dosages and precautions, were released by the Council on Rheumatic Fever and Congenital Heart Disease of the American Heart Association.[4]



DR. CONNOR

This study is concerned with the fate of 73 patients originally reviewed, and 25 patients discharged from the rheumatic fever ward during 1950 and 1951 on whom clinic follow-up is available. Of the 98 patients, 14 (14.3%) either left the Territory or did not, in my opinion, meet the criteria of Jones[5] for the diagnosis of rheumatic fever. There remained 84 children of whom 6 (7.1%) are dead: 3 of pancarditis during their first rheumatic episodes, 2 of congestive heart failure, and 1 of subacute bacterial endocarditis.

A period of follow-up was available for 78 living children. Forty-six (60%) of the 78 patients experienced a first attack during the study, and 32 (40%) were experiencing a recurrent attack of rheumatic fever when they came under observation.

Clinic examinations revealed that 24 (30.8%) of the children had no organic cardiac murmurs. The murmur of mitral insufficiency was heard in 30 (30.5%) and the murmur of mitral insufficiency combined with the murmur of either mitral stenosis or aortic insufficiency was heard in 11 (14.1%). Five (16.4%) had the murmur of aortic insufficiency. Eight children (10.3%) had developed new murmurs during the period of observation. Twenty-six (33.3%) of the children had cardiac enlargement at the time of the last chest roentgenogram. Six of the 78 living patients had chorea. These children had numerous exacerbations with minimal or no cardiac damage, and emotional problems dominated their clinical pictures.

In 1949 prophylactic drugs were started on some of the more severely involved children. Drugs were used more extensively as studies done elsewhere demonstrated their efficacy in preventing recurrences. Sulfadiazine or Gantrisin was given in a dosage of 0.5 gram daily to children under 7 years of age and 1.0 gram daily to those over 7 years of age. Oral penicillin dosage varied between 200,000 and 400,000 units daily.

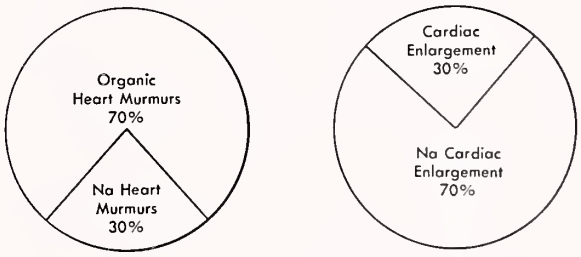


FIG. 1—Status of rheumatic fever patients in regard to heart murmurs and cardiomegaly at the end of the period of observation.

Drugs were not given to alternate patients, and thus the selection was not on a random basis. Also, particularly in 1948 and 1949, prophylactic drugs tended to be given to those children with moderate to severe cardiac damage. By 1951 drugs were prescribed on almost all children who had had an

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[1] Connor, A., Yoshina, T.: Rheumatic Fever in Hawaii, HAWAII MED. J. 10:181 (Jan.-Feb.) 1951.

[2] Wilson, M. G.: Natural History of Rheumatic Fever in the First Three Decades, J. Pediat. 10:456 (Apr.) 1937.

[3] Hansen, A. E.: Rheumatic Recrudescences: Diagnosis and Prevention, J. Pediat. 28:296 (Mar.) 1946.

[4] Breese, B. B., et al: The Prevention of Rheumatic Fever, Public Health Reports 68:12 (Jan.) 1953.

[5] Jones, T. D.: The Diagnosis of Rheumatic Fever, J.A.M.A. 126: 481 (Oct. 21) 1944.

attack of rheumatic fever. From these studies it was not possible for us to present recurrence rates in children given prophylactic drugs compared with rates in a control group not given the drugs. Rather, we have had to compare recurrences of rheumatic fever by patient months on a prophylactic drug, with recurrences by patient months when no prophylactic drugs were being taken by the child. It seems reasonable to assume that many of the children who did not take the prescribed drugs came from home situations where their care in general was poor. This fact is probably counterbalanced by the fact that for several years drugs were given to children who appeared to be most susceptible to recurrences based on residual cardiac damage.

Fifty-seven (73.1%) of 78 patients had a prophylactic drug at one time or another during the follow-up period. Twenty-six (45.6%) of them had sulfa for a time, and were later changed to penicillin.

Of 57 patients for whom a drug was prescribed, 26 (46.6%) did not take the drug regularly.

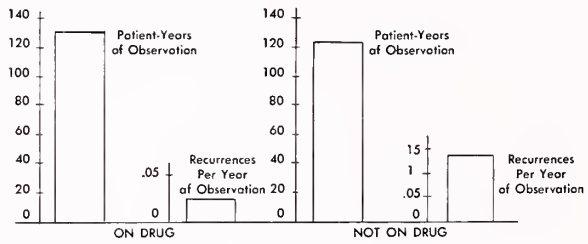


FIG. 2—Recurrence rates by patient year of observation comparing rates of recurrence when drugs were taken with rates when drugs were not taken.

Neither parents nor children appeared to realize the importance of continuous prophylactic medication. Efforts to strengthen the educational program for both parents and children during hospitalization and extension of the follow-up activities by public health nurses is essential if children are to be kept on prophylactic drugs. In addition, a medical social worker should be available at the clinic so that particularly difficult problem cases can be referred to her for case work services.

Eliminating the 6 patients who had chorea, 72 patients were observed for 260 patient years, or an average of 3.6 years per child. The charts of the children were reviewed, and 25 recurrences in 16 children were believed to meet the criteria for the diagnosis of a recurrence.

In spite of the difficulties encountered in getting children to take their drugs regularly, a significant amount of protection from recurrences accrued to children for whom the drugs were prescribed. Of the 25 recurrences, 18 developed while no drugs were being taken, and 7 were presumably drug failures. Studies of these 7 episodes revealed that in only 2 instances were we certain that the children were taking the drug regularly. Even if those 7 attacks are considered drug failures, .14 recurrences per year of observation were experienced by children on no drugs as compared to .05 recurrences per year while drugs were being prescribed.

In spite of the fact that poorer risk patients were put on drugs, and that almost one-half of the patients on the drugs did not take them regularly the recurrence rate per year of observation was nearly three times higher for children getting no drugs than it was for children for whom drugs were prescribed.

Conclusions

The mortality among 84 rheumatic children followed for an average period of 3.6 years was 7.1%.

More than two-thirds of the living children have organic cardiac murmurs, and one-third of them have cardiac enlargement.

Recurrence rates per year of patient observation were three times higher in children taking no drugs as compared to children for whom prophylactic drugs were prescribed.

Great difficulty is encountered in persuading children coming to a clinic to take drugs regularly.

Intensive educational programs aimed at rheumatic children and their parents during and after hospitalization are essential, and more efforts in follow-up both by public health nurses and social workers are indicated if the full benefits of prophylactic medications in preventing recurrences of rheumatic fever are to be attained.

Acknowledgment

The assistance given by Miss Yoshie Gushikuma and Mrs. Clara Horn is gratefully acknowledged.

Territorial Department of Health.

DERMATITIS DUE TO CONTACT WITH THE HYDROID, SYNCORYNE MIRABILIS (AGASSIZ, 1862)

GEORGE W. T. C. CHU, Sc.D., AND
CHARLES E. CUTRESS, M.S., Honolulu

DERMATITIS resulting from contact with marine hydroids (phylum Coelenterata) has been observed many times in the Hawaiian Islands by the authors. De Oreo,[1] in 1946, reported 52 cases from the island of Oahu which he attributed to contact with Halecium beani. However, we believe the following account to be the first incriminating free-floating parts of hydroids (rather than the attached colony) and the first implication of the species, Syncoryne mirabilis.



DR. CHU

Data and Discussion

The area near the mouth of the Wailoa River in Hilo Harbor was visited on November 22, 1954,[2] to determine the cause of dermatitis occurring among construction men working on a small boat pier (Fig. 1). During the previous month approximately twelve men who had entered the water to work on the pier were reported to have contracted a dermatitis of variable severity.



FIG. 1—Area of operations in Hilo Harbor near the mouth of the Wailoa River.

Three men exhibiting dermatitis of about two weeks' duration were examined. Of these one man had almost recovered, a second (Fig. 2) bore purple scars one-fourth to one-half inch in diameter upon his legs and abdomen, and the third had fewer and smaller lesions of the same type, several of which had become purulent sores. All



FIG. 2—Sequelae of focal skin lesions on thighs of one man.

three men claimed to have experienced a prickling sensation while immersed in the water. Six to twelve hours later an intensely itching, dispersed, papular eruption appeared and persisted for several days before subsiding. The lesions were most numerous on areas of the body that had been covered with clothing (most of the men worked in the water fully clothed) but were also present on uncovered parts.

Examination of the rocky shore and bottom in the immediate vicinity of the pier revealed that many of the large, submerged lava rocks were covered with a small hydroid which was later identified as Syncoryne mirabilis[3] (Fig. 3). While searching for possible dermatitis-producing or-

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[1] De Oreo, G. A.: Dermatitis venenata resulting from contact with marine animals (hydroids); report of cases. Arch. of Dermatol. and Syphilol. 54:637 (Dec.) 1946.

[2] The authors appreciate the courtesy and assistance extended during the study by the personnel of James W. Glover, Ltd., and the Hilo Branch of the Department of Health, T. H.

[3] Fraser, C. M.: Hydroids of the 1934 Allan Hancock Pacific Expedition. Allan Hancock Pacific Expeditions 4 (1):7, 15, 1938.

Fraser, C. M.: Hydroids of the Pacific Coast of Canada and the United States, p. 28, pl. 3, 1937, and Hydroids of the Atlantic Ocean, p. 41, pl. 4. The University of Toronto Press, Toronto, 1944.

ganisms the junior author noticed that walking on the hydroid-covered rocks dislodged the hydroids, their medusae, or their tentacles, and these free-floating pieces, carried against him by the surging water, caused a prickling sensation. This experience, together with the nature and distribution of the lesions on the men, showed that the dermatitis was contracted from floating polyps, tentacles, and medusae and not from contact with the attached colonies.

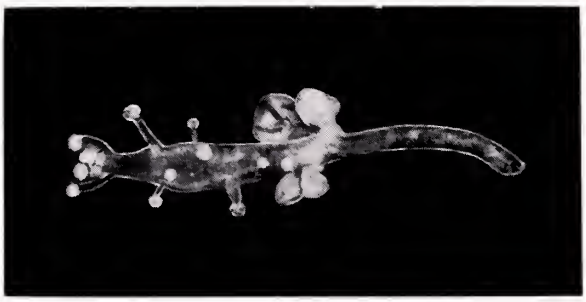


FIG. 3—Syncoryne mirabilis.

Small colonies of freshly collected Syncoryne were applied to the upper arms and abdomens of the authors and one man who had previously contracted dermatitis at the pier. In this test all three persons experienced a prickling sensation and a reddening of the area exposed to the hydroid. No dermatitis appeared on the authors; but after about ten hours, a fine papular eruption occurred on the man who had previously had dermatitis (Fig. 4).



FIG. 4—Patch test site on arm of one dermatitis victim after ten hours.

In response to a plea for relief of the men's discomfort, several methods of control were considered. The small confined area in which the men worked and the swift current around the pier (Fig. 1) excluded possibilities of complications resulting from the use of a chemical control agent. With these considerations in mind large crystals of copper sulfate were scattered over the bottom at the rate of about 30 pounds per 5,000 square feet. The use of large crystals brought about a higher concentration of the reagent near the bottom where the hydroids grew. Examination of the rocks ten hours after the application of copper sulfate showed that the hydroids were dead and, in fact, the polyps were decomposed and washed away.

The specimens of hydroids taken at the pier in Hilo, Hawaii, agree well with Syncoryne mirabilis (Agassiz, 1862).[4] It is a cosmopolitan species and is usually less than one centimeter in height, although the colonies may spread over an area of several square feet. The erect polyps arise from creeping stolons and bear fifteen or more capitate tentacles. The medusoid generation (the medusae of Syncoryne bear the generic name, *Sarsia*) appear below the tentacles where they attain sexual maturity before liberation from the polyp (Fig. 3). Reference to an extensive personally compiled bibliography on all types of invertebrate-induced dermatitis indicates this to be the first time hydroids of the genus Syncoryne have been incriminated as dermatitis producers.

Summary and Conclusion

Investigation of an outbreak of dermatitis among men working in the water on a small boat pier near the mouth of the Wailoa River in Hilo Harbor, Hawaii, was shown to be caused by the hydroid, Syncoryne mirabilis (Agassiz, 1862).

The dermatitis resulted from contact with pieces of the hydroid colony (scuffed from the rocks by the men's walking on them) which were carried beneath the clothing and against the men by the surge of the water. The ensuing dermatitis was of variable severity and usually did not persist for more than three weeks.

A thorough search of literature on cases of invertebrate-induced dermatitis indicates this may be the first time hydroids of the genus Syncoryne have been incriminated as dermatitis producers.

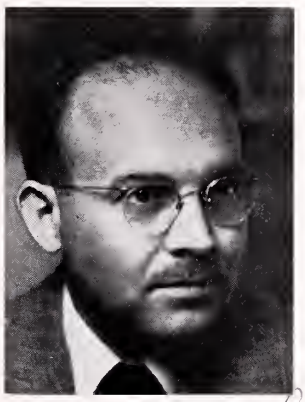
[4] Agassiz, L.: Cont. Nat. Hist. U. S. 4:185; 3, figs. 1-16, plate 17, figs. 1-14, plate 18; figs. 1-27, plate 19. 1862.

MICROSPORUM GYPSEUM IN HAWAIIAN SOIL

Or, Don't Kill the Cat

SAMUEL D. ALLISON, M.D., Honolulu

IN 1952 a ten-year-old girl was seen for the management of an unusual lesion on the knee, made up of closely aggregated moist papules with no tendency toward central clearing. Sabouraud cultures produced M. gypseum.[1]



DR. ALLISON

In 1954 another young girl was seen with a lesion on the leg that began "terribly red and raised like the beginning of a boil." This lesion had an active ringed border but incomplete central clearing. Cultures revealed M. gypseum.[1] Neither of these patients had a history of contact with cats.

Lewis[2] has remarked that this fungus was "apparently imported from South America . . ." On the first demonstration of the organism here I speculated that the fungus might have been imported to Hawaii with the immigration of racial groups common to South America, but this explanation did not seem entirely logical. In 1950, Sharp[3] remarked that this fungus was not as uncommon as Lewis' description appeared to make it. The matter was further elucidated in 1953 when Ajello[4] isolated M. gypseum from soils examined from a wide variety of geographic sites. Hawaii was not included in Ajello's list of areas from which the fungus had been reported as causing disease. Recently Ajello[5] recovered this organism from 23 of 100 Hawaiian soils tested. In view of the presence of this organism in the soils of all of the major islands, a clinical note concerning the disease seems in order.

It is likely that this organism would be found much more often if cultures were more regularly made of body and scalp "ringworm"—and that the life of the common cat would be less in jeopardy. It seems remarkable that so few cases of this infection have been seen when Hawaiian soils yield the fungus so frequently.

Summary

M. gypseum is reported as existing in Hawaiian soils and having produced clinical disease in the Territory.

Received for publication March 15, 1955.

[1] Laboratory diagnosis by Marguerite Beatty, Board of Health Laboratory, Honolulu, T. H.

[2] Lewis, G. M., and Hopper, M. E.: An Introduction to Medical Mycology, The Year Book Publishers, Inc., Chicago, 1948, p. 288.

[3] Sharp, W. B., and Wegner, M.: Microsporum Gypseum as an Etiological Agent of Tinea in the United States, A.M.A. Arch. Dermat. & Syph. 61:824 (May) 1950.

[4] Ajello, L: The Dermatophyte, Microsporum Gypseum, as a Saphrophyte and Parasite, J. Invest. Derm. 21:157 (Sept.) 1953.

[5] Ajello, L.: (Personal Communication) Public Health Service, Communicable Disease Center, Mycology Laboratory, P. O. Box 185, Chamblee, Georgia.

Levine, M.: (Personal Communication) The Department of Health, Territory of Hawaii, assisted in Dr. Ajello's study.

Alexander Young Building.

CERVICAL PREGNANCY

Report of One Case

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TRUE *ectopic* pregnancy develops in only two areas of the human female generative tract, namely, (1) the interstitial portion of the uterine tube, and (2) the canal of the uterine cervix. All pregnancies that nidate outside the boundaries of the cavity of the womb are *extra-uterine*. The incidence of ectopic gestation, therefore, is very small; and the rarer of the two types is cervical.



DR. BACHMAN

Isthmico-cervical implantation, the cervical phase of uterine abortion, and early placenta previa are frequently mistaken for cervical pregnancy; but the error can be rectified by applying the four standard criteria[1] of identification to the gestation in question. Thus defined, many presumed cases of cervical pregnancy have turned out to be otherwise.

During the past decade, two published summaries[2] of the proven cervical pregnancies registered since 1887, when the first one[3] was described, place the total number at 45. Individually reported cases[4] since March, 1953, raise the figure to 54. The fact that only 28 were seen in the 58 years before 1945, and that an almost equal number have been reported in the ten years since, raises the question of whether the incidence has increased to that degree or whether many cases in the past went undetected. The latter explanation most likely clarifies this statistical curiosity.

Implantation of the fertilized ovum on the columnar epithelium of the cervical canal, and development of a pregnancy at that site, constitute a fundamentally incompatible situation. The endocervical tunica mucosa does not participate in the hormonal-histological cycle of the endometrium; hence, there is no proliferative or secretory change to properly support placentation. The cervical wall itself contains only scattered smooth muscle fibers, so the hypertrophy of mural layers necessary to accommodate the increasing bulk of a living conceptus is not generally possible. Although the blood supply of the uterine cervix is more than adequate to meet the demands of a pregnancy, true gestational vascular sinus formation cannot occur because of the scarcity of smooth muscle bundles in the substance. So the extension of placental villi to establish fetal circulation becomes a direct invasion of the blood vessels of the cervix.

These facts also explain why most cervical pregnancies do not proceed beyond the sixteenth week of gestation, and why all of them have come to medical management because of massive uterine (cervical) hemorrhage at the time nature attempted to extrude them.

Among the half million people of the Territory of Hawaii, one case[5] of cervical pregnancy has already been described. Hereinafter is the report of another case, this one from the private practice of the present author.

Case Report

O. J. C., aged 24 years, Caucasian, married, was gravida 2, para 1, aborta 0. Her family history was noncontributory. She had had the usual childhood diseases; occasional upper respiratory infections; no general surgery, and no major trauma.

Her first pregnancy was uncomplicated, with spontaneous delivery of a living female infant at term; early puerperium was normal. Uterine hemorrhage occurred fourteen days following delivery; curettement was done, transfusion was given; retained placental fragments were removed.

She was first seen for the present pregnancy on August 10, 1954, with complaints of morning nausea, vomiting, and vague lower abdominal, midline cramps. The last normal menstrual period had begun July 5, 1954, on regular cycle.

From the Gynecology Division of Kapiolani Hospital.

Received for publication March 21, 1955.

[1] Rubin, I. C.: Cervical Pregnancy, Surg., Gynec. & Obst. 13:625 (Dec.) 1911.

[2] Studdiford, W. E.: Cervical Pregnancy, Am. J. Obst. & Gynec. 49:169 (Feb.) 1945.

Baptisti, A., Jr.: Cervical Pregnancy, Obst. & Gynec. 1:353 (Mar.) 1953.

[3] Tarnier, E., cited by Devraigne, L.: Contribution a l'étude de la grossesse isthmico-cervicale, Obstétrique 16:959, 1911.

[4] Dekaris, M.: Cervical Pregnancy, abstracted in Excerpta Medica Sec. X 7:494 (Nov.) 1954.

Yenen, E.: A Case of Cervical Ectopic Pregnancy Simulating Chorion-epithelioma, abstracted in Excerpta Medica Sec. X, Congress Number, International Congress of Gynaecology and Obstetrics 7:326 (Aug.) 1954.

Flanagan, J. F. and Walsh, C. R.: Cervical Pregnancy, Obst. & Gynec. 4:511 (Nov.) 1954.

Hennessy, J. P.: Cervical Pregnancy, Am. J. Obst. & Gynec. 67: 1155 (May) 1954.

Burstein, H. A.: Cervical Pregnancy, Am J. Obst. & Gynec. 68:940 (Sept.) 1954.

Cave, W. H.: Cervical Pregnancy, Illinois M. J. 105:325 (June) 1954.

[5] Bowles, H. E.: Cervical Pregnancy, West. J. Surg. 53:226 (July) 1945.

Pelvic examination revealed the single positive finding of questionable uterine enlargement consistent with early pregnancy. A presumptive diagnosis of uterine pregnancy was entertained, and therapy for the emesis gravidarum instituted. Pelvic examination was repeated August 20, 1954, and a definite diagnosis of uterine pregnancy established. General physical work-up and laboratory investigation were carried out on September 2, 1954, all findings being within the limits of normal.

She returned for routine prenatal examination on October 4, 1954. The pregnancy appeared to be progressing normally, with fundus height one-third of the distance to the umbilicus. Nine days later, she came in because of urinary frequency and dysuria of one day's duration. There had also been very scanty uterine bleeding for the same interval. No cramping had developed, but the degree of lower abdominal discomfort made subjective differentiation of pain difficult. Urine analysis showed innumerable white blood cells and scattered red blood cells per high power field, along with albumin 2 plus. Diagnoses of pyelocystitis of early pregnancy and threatened early abortion were made. Antibiotics and chemotherapy were instituted for the infection, and progesterone 50 mgm. was given intramuscularly for the threatened abortion. She was instructed to report immediately any increase in uterine bleeding or the development of uterine cramps or backache.

She returned after four days, as directed, for evaluation of her clinical condition. The urinary tract symptoms had subsided, and urine analysis was negative. Uterine bleeding had persisted at the same rate. She described it as "streaking" only. No lower abdominal cramps or backache had been noted. Estrogen-progesterone (Cyclogestrin) was given intramuscularly, and she was instructed to return in four days or to report immediately any additional untoward developments. On October 26, 1954, she reappeared with the information that uterine bleeding had continued in the same quantity. Pelvic examination was done. A very small amount of brownish mucus was present in the external cervical os; the corpus uteri was the size of a 12-week pregnancy, and seemed normal in shape and consistency. Another ampule of estrogen-progesterone was administered. She was told to remain at relative rest at home and to advise immediately upon further unfavorable signs. Two days later she came in because of abdominal cramps that had developed that morning soon after arising. No increase in uterine bleeding had occurred. Abdominal examination disclosed neither rhythmical uterine contractions nor increased tonus of the myometrium. Estrogenic substance (Premarin) 20 mgm. was given intravenously, and the patient was informed hospitalization would be necessary if symptoms became more severe. She returned home on relative rest and mild sedation.

On November 1, 1954, her sister called to report that the patient had experienced sudden profuse vaginal bleeding and was passing large clots, although only slight cramping was present. Immediate hospitalization was ordered. Excessive but not hemorrhagic uterine bleeding was present; blood pressure was 110/70, pulse was 92 and good quality, respirations were 22. The skin was pale, but not cold or clammy. On the assumption an incomplete uterine abortion had occurred, speculum examination of the vagina and cervix was done with expectation of encountering most of the products of conception lodged in the vagina and the cervical canal. Instead, the vagina was filled with fresh clots that extruded themselves when the speculum was opened, leaving the cervix exposed. The external cervical os was dilated 3 centimeters, revealing a bluish mass within. The walls of the portio vaginalis of the cervix were symmetrically distended to the approximate diameter of 12 centimeters, producing an equal expansion of the upper third of the vagina. Active bleeding proceeded from the os. Tentative diagnosis of the cervical stage of uterine abortion was made, and the patient readied for operative evacuation of the secundines. Transfusion had been started. The blood pressure was still 110/70, and her general condition was satisfactory.

She was transferred to the operating room, prepared and draped for vaginal surgery. Bimanual pelvic examination revealed a widely distended portio vaginalis cervicis with the external os dilated 3 centimeters. The corpus (?) uteri filled the true pelvis and extended one-half the distance to the umbilicus. It was soft and rubbery, as if filled with fresh blood clots. Adnexa were not palpably enlarged. The cervix was exposed, and the findings noted on vaginal palpation and previous speculum examination were again displayed. The mass contained within the expanded cervix was dark blue, with strands of fibrin laced through it. Profuse uterine bleeding was in process, so care was taken during the vaginal palpation not to disturb the secundines.

With sponge forceps, an attempt was made to remove the material in the cervix. Only very small pieces could be dislodged, and the mass was surprisingly firm in consistency. Each piece withdrawn produced more bleeding. Finger curettement was then tried, with some success. But the entire substance was so dense and adherent that when that portion against the anterior wall of the cervix finally came away, it carried so much of the cervical wall with it, it was feared the bladder had been injured. A catheter was immediately inserted in the bladder and careful palpation done to ascertain what damage had been done to the vesical wall. Fortunately none had occurred, but the few layers of cervical tissue that remained were so thin it was almost impossible to identify them as such. The remainder of the adherent tissue was digitally extracted to the depth where its adherence to the cervix was so complete any further removal would have torn into the wall again. This left a considerable quantity of secundines in situ, but the bleeding there was much less than that gushing from the area where the inner layers of the cervix had been torn away earlier in the procedure.

The anesthetist reported that the patient was in shock. The blood pressure had fallen to 80/40, the pulse was 120, of fair quality; the respirations were regular and deep. Blood transfusion had been maintained continuously. The working diagnosis was changed from the cervical stage of uterine abortion to early placenta previa, adherent but not increted.

With most of the secundines out of the cervix, it was possible to palpate the cavity they had occupied and to investigate the structures higher up. The internal cervical os was barely one centimeter dilated. The corpus uteri could be felt riding above the distended cervix. It was slightly enlarged, and the walls were 2-3 centimeters thick and firmly contracted. Its relation to the expanded cervix was similar to that of a sessile uterine fibroid to an enlarged fibrotic fundus uteri.

Sharp curettement of the uterine cavity was done, but only hypertrophied endometrium was obtained. So it was concluded there were no elements of the pregnancy there; hence no bleeding from that source. The uterine cavity, the cervical cavity, and the vagina were tightly packed with a 2-inch gauze roll. Oxytocics in the form of ergotrate and pitocin were given intravenously. The patient was in profound shock. Blood pressure was detectable at systolic level only, ranging between 30 and 70. The pulse was thready and inconsistent, the true

rate being uncertain. Respirations were 20-30 per minute but still deep and effective. Continuous transfusion of whole blood was being maintained.

In a few minutes, the patient had bled through the pack. The packing was removed. The uterine cavity was sounded and the cervical cavity palpated for possible perforation. None was found. A second pack was placed. She soon bled through it. Profound shock continued, so she was prepared for abdominal hysterectomy.

Through a midline, suprapubic incision, the pelvic viscera were exposed. The corpus uteri was found perched on top of a cylindrically distended cervix that filled the entire cavity of the true pelvis. The corpus was only slightly enlarged, was symmetrical, and grossly resembled the fundus of early pregnancy. The adnexa were normal. The ovaries, tubes, and round ligaments were ligated and freed from their uterine attachments. The bladder was deflected, the uterine arteries were ligated, the pack was withdrawn from below, and the corpus uteri amputated at the utero-cervical junction. The cervix could then be looked into from above. It was distended to the diameter of 15-20 centimeters, and contained tags and shreds of placental tissue interspersed with organized blood clot. No fetus was seen, and none had been found among the material previously removed vaginally.

The walls of the cervix were so thin where the secundines had been torn away during the finger curettement that some areas opened through when the remainder of the bladder deflection was done. The cervix was then removed in routine fashion. The vaginal vault was closed, and its support reestablished by attaching the ligament pedicles to it. After peritonealization, the abdomen was closed in layers and the surgery completed.

Profound shock had persisted, but soon after closure of the skin incision, the blood pressure began to rise, the pulse slowed and became regular, and the general condition improved. The respirations, interestingly enough, had never been seriously embarrassed. The patient was completely recovered from shock within one hour, and had reacted sufficiently from the anesthetic to recognize her surroundings and her family.

The surgical specimen was opened and examined closely. The nature of the lesion was then obvious. It was a cervical pregnancy. The clinical diagnosis was

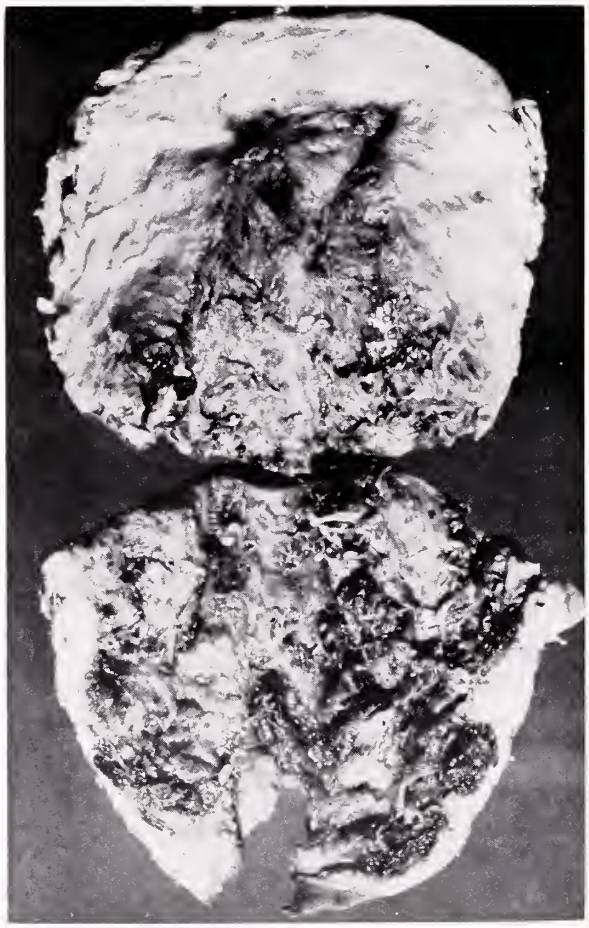


FIG. 1—Posterior half of uterus and cervix after formalin fixation and longitudinal section for laboratory examination. In the upper segment, which consists of the corpus et fundus uteri, can be seen the cornual areas and the other anatomical boundaries of the uterine cavity. The lower segment is the greatly distended cervix. Areas of placental implantation are visible along the wall with sites of hemorrhage and invasion clearly discernible.

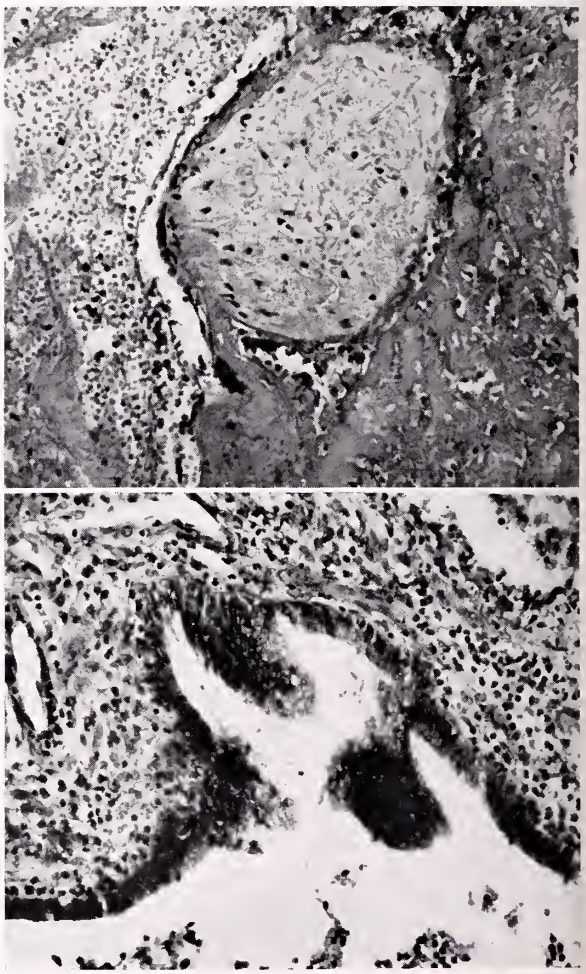


FIG. 2—Photomicrograph of a section taken through the cervical wall at a site of placental implantation. The upper frame contains a sclerotic placental villus. The lower frame contains a cervical gland. Although not photographable in the same microscopic field, these two structures were located 6 mm. from each other in the single section of cervical tissue (200 ×).

changed to cervical pregnancy, with hemorrhage and shock.

The patient was placed on large doses of antibiotics and intensive hematinic therapy. She was given one transfusion the day following surgery. The red count on the second postoperative day was 2.98 million, hemoglobin was 63%, white count 13.4 thousand. Another unit of blood was given. The blood count on the fourth postoperative day: red cells 3.45 million, hemoglobin 70%.

The general postoperative course was entirely uneventful. She was discharged on the seventh day in good condition.

Exactly two weeks following surgery, vaginal bleeding of moderate quantity developed. She was immediately hospitalized. Examination revealed one bleeding point at the right angle of the vaginal vault closure. The rate of bleeding was slow. A pack of oxidized cellulose was inserted and the patient observed for forty-eight hours. No further beeding occurred, and she was discharged. Blood count taken on this admission showed red cells 3.81 million, hemoglobin 77%, and white count 9,800.

She was seen postoperatively on December 11, 1954. The abdominal incision was healed well. The vaginal vault was healing satisfactorily, and her general condition was good. She said she felt "fine." She was checked again on January 8, 1955. Healing was excellent, and she felt very well, even to requesting permission to resume her full household duties. On February 26, 1955, a general physical examination and routine laboratory investigation were done. All vital findings were normal. Healing was complete in the operated areas. Hemoglobin was 92%, red cell count 4.2 million, white cell count 9.2 thousand with normal differential. Urine analysis was negative. Patient reported she had "never felt better."

A review of the anesthetist's operation record shows that the patient was given a total of three and one-half hours of general anesthetic consisting of cyclopropane and oxygen, along with 2 cubic centimeters of curare at the time of the laparotomy. She was on the operating table for five and one-half hours, the last hour being for recovery observation.

She received 4500 cc. of whole blood and one liter of 5% glucose in water during her stay in the operating room. Oxytocics administered at the time of curettement consisted of ergotrate gr. 1/320, 2 ampules; and pitocin units 10, 3 ampules.

Tissue report by the pathologist, Dr. Raid Chappell:

"A complete uterus received in two portions, the cervix being separate, together measuring 12 centimeters long, 7.5 centimeters at its widest part in the lower cervical area, and 5 centimeters deep. The cavity is enlarged in the cervical segment and just within the os to 3 centimeters of the fundus. The transverse measurement of the latter from cornu to cornu is 2.5 centimeters. Diameter of the lower (cervical) segment at the level of 3 centimeters within the external os is 7.5 centimeters. The cavity, except in the fundus, is lined with very ragged, hemorrhagic mucosa. Myometrium is thin in the cervical segment, and in the fundus is about normal, being 2 centimeters. The cervical and endocervical myometrium is thinned so that it averages 0.7 centimeters in thickness, and most of this thickness is taken up by dilated-blood-filled vessels or sinuses, some of which measure 1.2 x 0.6 centimeters.

"80 cubic centimeters of hemorrhagic fragments of discolored brown tissue. The only piece lending itself to a gross diagnosis is a 6-centimeter membranous sheet of amniotic sac.

"Microscopic Examination:

"Sections taken from the cervical lip contain hypertrophy of the fibromuscular tissue fibers, a focal deciduoid reaction of these tissues, and large and extensive areas of necrosis and hemorrhage on the superficial or mucosal aspects. In the latter and nearly into the cervical stromal tissues are bits of necrotic placental villi, many of the tips of which lie in the region of and directly opposite to cervical glands in characteristic pattern. Finally, large blood-filled maternal sinuses or veins are noted.

"Sections from the central or sacular part of the endocervical segment show again hypertrophied fibromuscular stroma with foci of a deciduoid reaction. Here, the mucosal side or superficial aspect is not extensively necrotic nor is placental tissue here identified. And, finally, sections from the fundus display no visible preserved endometrial mucosa; a layer of necrotic material covers the entire cavity. One minute focus of superficial adenomyosis is found. No placental tissues or deciduoid reaction are present in the sections taken from the fundus.

"Extensively hemorrhagic and acutely inflamed necrotic material containing chiefly ghost-like remnants of placental villi, though a few viable but poorly preserved ones are found in the tissue identified as 'uterine contents.'

"Diagnosis: Uterus with implantation site of pregnancy in endocervical canal.

"Necrotic placental tissues."

Summary

1. A short discussion of cervical pregnancy is given.

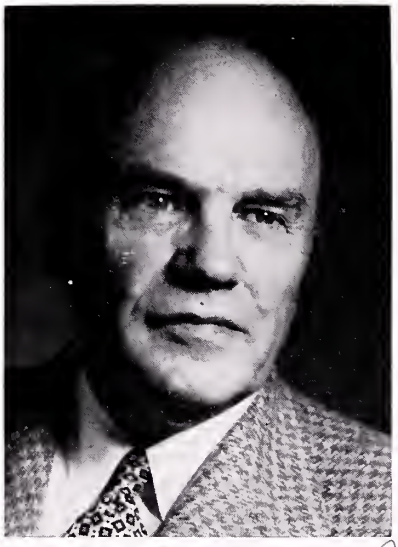
2. The report of one case of cervical pregnancy successfully treated by total abdominal hysterectomy is presented.

3. Clinical and histo-pathological evidence of this entity in this case is furnished.

Acknowledgment

Considering the exsanguinating hemorrhage, the prolonged surgical and hemogenic shock, the danger of postoperative bronchopneumonia, and the critical postoperative interval, it is obvious this patient would not have survived without adequate quantities of infused compatible whole blood, sufficient "straight" oxygen at operation, effective antibiotics, and capable nursing care. None of these life-saving measures could have been realized without the skilled and willing service rendered by the professional personnel of the hospital. Members of the resident staff, the (nurse) anesthetist, the operating room nurses, the laboratory technicians, and the general duty nurses performed their tasks with unexcelled efficiency. To all of these devoted people, I extend an expression of deepest personal gratitude.

The Fronk Clinic, 1136 Union Street.



NILS P. LARSEN, M.D.

The President's Page

This is my swan song. I have been honored to have served as your president and have tried hard to fulfill the duties required of this office.

Dr. Peter Murray, President of the Medical Society of the County of New York, visited us last year and sent us a copy of his inaugural address. I would like to quote from this because he touches on one subject which has seemed at the present time to be so important to all of us.

"The closed panel type of practice of medicine —especially when tied to an insurance plan that goes to the public and advertises for patients for such closed panels of doctors—is the greatest threat to the continued high level of medical care faced by the profession . . .

". . . I am not referring here to the ordinary contract practice of medicine such as a large company may have for the benefit of its employees . . . [So many have spoken of plantation medicine as purely panel medicine that I think we should keep this difference clearly in mind.] . . .

"I do refer to closed panel groups which obtain their patients by the devious and round-about method of advertising through the insurance company with which they are associated.

"Closed panel medical service, offered to the public on an insurance basis, carries great danger to the general profession, especially to young physicians entering the practice of medicine . . .

"It is even now becoming more and more clear that the 1,000 new graduates in medicine each year in New York find themselves excluded from the exercise of their talents in a free market. Larger and larger blocks of the population will find themselves committed to a choice of the supplier of their medical care limited to a few physicians not chosen because of superior ability; whose ranks are not subject to the constant infusion of new, able and modernly trained physicians, but limited to those few [who were chosen] . . .

"Has not open full competition provided American business and institutions with the healthy stimulus—the challenge—which calls forth the very best methods and products of American energy in the service of the American public? . . .

"The free choice of his physician is as dear to the American family as is his freedom of speech and freedom of worship . . .

". . . If the patient is dissatisfied with the brand of medical care he is receiving, he should be free without hobbling restrictions or fine print double talk in his insurance contract, to freely change his physician as he changes his grocer or his merchant. Only in this way can he receive the best value of service for his health dollar. . . ."

Let us try to work as a great cooperative and not call each other names but try to define clearly the ideas where we might differ. Perhaps by understanding we can attain a higher degree of cooperative fellowship.

Nils P. Larsen

Hawaii
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[EDITORIALS]

Ecology and Psychiatry

Social science is still, in many minds, the ugly duckling (or one of the ugly ducklings) of scientific endeavors. Much of its terminology is strange and obscure, often unnecessarily so. Man in the mass is still pretty mysterious, even to the experts.

An understandable article in this field, by Robert Schmitt and Harry Lee of the Honolulu Redevelopment Agency, appears on page 414 of this issue in our feature section, "Perhaps It's Your Nerves." Part of a larger sociologic study, it is entitled "The Geographical Distribution of Mental Disorders on Oahu." Mental health is in many ways the nation's—and Hawaii's—Number 1 health problem, and this article throws light on an interesting and potentially important facet of it. Be sure to read it!

Thanks to the Better Business Bureau!

A Chicago chiropodist attempting to practice medicine in Hawaii was exposed recently in Hilo by an investigation of the Better Business Bureau —to whom the medical profession here owes a vote of thanks, and rather better financial support than has been forthcoming in the past.

"Dr." Anthony Senese worked as an anesthesiologist for some weeks in a Honolulu hospital before arousing suspicion that his credentials were fraudulent. A preliminary investigation through the A.M.A., went to the wrong department there and disclosed only a record of his graduation from a Mexican medical school—a diploma mill closed several years ago by the Mexican government.

First actual evidence against Senese was obtained through the A.M.A.'s Bureau of Investigation (which had been watching him since 1944) as a result of the alertness of Dr. J. I. F. Reppun, to whom Senese had applied for a job. When Mrs. Edith Bennett, Executive Secretary of the Hawaii Medical Association, was informed of Senese's background, she notified Honolulu hospitals and the B.B.B. regarding it.

The B.B.B., working with the Public Prosecutor and the Department of Health, then sent an investigator to Hilo and obtained positive evidence that Senese was practicing without a license. Conviction followed swiftly, with a fine, suspended in part on condition of his leaving the Territory within a week.

We've learned to expect prompt and effective action in the public interest, where the Better Business Bureau is concerned. Let's not take it for granted, though—and please consider joining it and supporting it. It's doing a good job for us.

Surgeon-General Hogan

"Bart" Hogan's many Island friends will be pleased to know that he was confirmed as the Navy's new Surgeon General on February 18.

Rear Admiral Bartholomew W. Hogan, to give him his full title and name, graduated from Tufts, in his native state of Massachusetts, in 1925, and entered the Navy medical service immediately. He has been Rear Admiral since August 9, 1952. His special field has been neuropsychiatry for the past 25 years. He was multiply decorated for distinguished service, valor, and injuries, following the

sinking of the *Wasp* in 1942. He has achieved professional distinction too, both in his special field, as an examiner for the American Board of Psychiatry, and in organized medicine, as a member of the House of Delegates of both the American Medical Association and the American Hospital Association.

Congratulations, Admiral Hogan, on the new job. It couldn't have happened to a nicer guy!

Guillermo Osler, M.D.

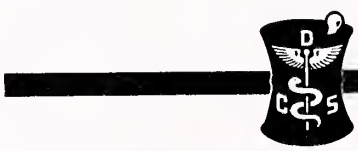
Next time you're browsing in the library, pick up the current issue of *Arizona Medicine* (it's on the shelf beneath the *mauka* window) and look around its middle for a colyum called "Topics of Current Medical Interest, RX., DX., AND DRS." by Guillermo Osler, M.D. Presumably the Guillermo (Spanish for William, in case you didn't know it) stems from Arizona's preoccupation with Spanish, through its history and its proximity to Mexico. The Osler part seems to owe its origin to his admiration for Sir William Osler, whom he occasionally quotes. Such a quote is reprinted below.

Guillermo is evidently a practicing physician, an internist by preference. He keeps up with the times pretty well, judging by his calling pyrizinamide (for tuberculosis) "old-fashioned." He reads and corresponds voluminously and to good purpose, and his quotations from both sources are lively, readable and informative.

"No class of men needs friction so much as physicians; no class gets less. The daily round of a busy practitioner tends to develop an egoism of a most intense kind, to which there is no antidote. The few set-backs are forgotten, the mistakes are often buried, and ten years of successful work tend to make a man touchy, dogmatic, intolerant of correction, and abominably self-centered.

"To this mental attitude the medical society is the best corrective, and a man misses a good part of his education who does not get knocked about a bit by his colleagues in discussions and criticisms. . . . The very marrow and fitness of books may not suffice to save a man from becoming a poor, mean-spirited devil, without a spark of fine professional feeling, and without a thought above the sordid issues of the day. . . . The man who knows it all and gets nothing from the society reminds one of that little dried-up miniature of humanity, the prematurely senile infant, whose tabetic marasmus has added old age to infancy. . . . He feels better at home, and perhaps that is the best place for a man who has reached this stage of intellectual stagnation."

—Sir William Osler
Counsels and Ideals from the Writings of William Osler



"Integrity — an ingredient in every prescription"

This is What's New!

Meticorten, a new synthetic steroid, is about **four times as effective as cortisone,** milligram for milligram. Although chemically identical to cortisone, except for the removal of two hydrogen atoms, it has strikingly different physiological properties. Its chief advantage over cortisone or hydrocortisone is that it does not cause sodium retention with associated edema. (*J.A.M.A.* [Jan. 22] 1955; and Schering Bull. [Feb.] 1955).

* * *

The Mayo Clinic has found that 50 per cent of their patients with **pleural effusion** had **malignant neoplasm,** 10 per cent were in congestive heart failure, and in about 10 per cent the pleural effusion was due to infection with tuberculosis as the most common cause of infectious pleural effusion. Miscellaneous causes, such as lupus erythematosus, cirrhosis, etc., explained the effusion in about 12 per cent of the patients. This left approximately 20 per cent of patients with pleural effusions that defied diagnosis. (*New Eng. J. Med.* [Jan. 20] 1955).

* * *

The summary of the Fourteenth Conference on the Chemotherapy of Tuberculosis is most encouraging. Since triple drug treatment—**streptomycin, INH, PAS**—was introduced two years ago in the treatment of **genitourinary tuberculosis,** the urine has been cleared of tubercle bacilli in 100 per cent of patients treated, and partial or complete nephrectomies have become an almost obsolete procedure for this disease. The results in therapy of genital tuberculosis have been about the same as with urinary tuberculosis.

Also with triple drug therapy, 95 per cent of patients with miliary tuberculosis are now surviving. The surgical trend in the treatment of tuberculosis in the past year has been characterized by **more segmental resections** and fewer pneumonectomies and lobectomies.

* * *

A careful clinical study set up by rheumatic fever workers in the United Kingdom and United States has just been reported. The purpose of this study was to answer two questions: (1) What is the relative effectiveness of **ACTH, cortisone,** and **aspirin** in altering the course of **acute rheumatic fever** or in suppressing its clinical manifestations? and (2) What is the relative effectiveness of these three agents in preventing rheumatic heart disease? Their conclusions, after reviewing charts on 500 patients were: (1) None of the agents used resulted in uniform termination of the disease or manifestations, and while the hormones resulted in more rapid control of acute manifestations, there was a greater tendency for acute symptoms to reappear after hormone treatment was stopped; and (2) At the end of one year, there was an **equal incidence** of **success and failure,** regardless of the type of treatment, whether it was aspirin, cortisone, or ACTH. (*Circulation* [Mar.] 1955).

* * *

Bailey of Philadelphia reviews the surgical treatment of **aortic insufficiency.** After trying various arrangements, he has ended up with a **two-tailed** plastic **pollywog.** The tails are sutured to the wall of the aorta anchoring the plastic ball in place. During systole, the plastic prosthesis is forced away from the aortic valve and during diastole, it falls back against the valve to prevent regurgitation. Twenty-three patients have undergone the operation with 7 deaths. Most of the survivors have shown marked benefit. (*Ann. Int. Med.* [Feb.] 1955).

* * *

The question no longer is how is your hemoglobin, but rather what is your hemoglobin? From the University of Oregon Medical School comes the history of a Chinese family with a severe microcytic hypochromic anemia associated with an enlarged spleen. Electrophoretic studies revealed a new hump, to be called **hemoglobin H.** This is the **sixth abnormal hemoglobin** discovered in the past six years. (*Science* [Mar. 11] 1955).

* * *

Two French surgeons have reported cures of **gastric and duodenal ulcers** with the use of **procaine.** Procaine is injected into the left prefrontal lobe of the brain. They believe the procedure is superior to lobotomy and in 35 cases had 1 death and no psychic sequelae. The majority of the patients undergoing the injection had intractable pain due to malignancy. (*Ann. Surg.* [Mar.] 1955).

FRED I. GILBERT, JR., M.D.

Perhaps It's Your Nerves

The Geographical Distribution of Mental Disorders on Oahu

ROBERT C. SCHMITT, M.A., AND HARRY K. LEE, B.A.*

This study describes and analyzes the geographical distribution of mental disorders on the Island of Oahu, as indicated by first admissions to Territorial Hospital. Findings are based on data compiled originally for the Honolulu Redevelopment Agency.[1]

Similar analyses have been made in a number of mainland areas during the past two decades. The outstanding example is unquestionably the Chicago investigation reported by Faris and Dunham in 1939.[2] More recent studies have been summarized in a critical review written by Clausen and Kohn and published in 1954.[3] No comparable research has been undertaken in Hawaii prior to the present study, however.

The geographical distribution of mental disorders on Oahu was measured by the average annual number of first admissions to Territorial Hospital, 1948-1952, per 1,000 non-institutional civilian residents, 1950, for each of the forty-two census tracts into which the island has been divided. Data on place of residence at time of admission were compiled by the authors from hospital records; population was obtained from the 1950 U. S. Census. Military personnel and persons admitted from other institutions (chiefly Oahu Prison, Kawailoa Girls' School, and Waialee or Koolau Boys' Schools) were not included in the tabulations.

It should be emphasized that this study was confined to persons admitted to Territorial Hospital, without regard to cause for admission. Limitations of sample size necessarily precluded a breakdown by type of disorder. The authors did not have access to the records of the Mental Health Unit of the Queen's Hospital, the Territorial Bureau of Mental Hygiene, or private psychiatrists. Thus, many mentally ill persons, particularly those with less severe disorders, were omitted from the survey. Furthermore, no differentiation could be made among the various classes of mental breakdown.

Despite these limitations, however, it is likely that the present analysis presents a reasonably accurate picture of the geographic distribution of the more serious kinds of mental disorder. Discussions with local psychiatrists indicated that the majority of acutely disturbed patients are ultimately committed to Territorial Hospital, the only institution in Hawaii devoted exclusively to mental illness. Furthermore, relatively few persons with minor disorders are admitted to Territorial Hospital: during the five-year period ended June 30, 1952, 70.2 percent of all first admissions (including those from places other than Oahu) were for psychotic disorders, compared to 11.6 percent for psychoneuroses, 6.2 percent for alcoholism, 2.8 percent for primary behavior disorders, 2.3 percent for drug addiction, 2.3 percent for psychopathic or pathological personality, and 4.5 percent for others without mental disorder.[4]

The Island-wide average annual number of first admissions per 1,000 non-institutional civilian residents was 0.78. The rate was 0.81 for Honolulu and 0.67 for the rest of Oahu.

Among individual census tracts, the rates ranged from 0.07 in the tract comprising Schofield Barracks to 3.15 in the central business district. The highest rates, after the central downtown area, were reported for the River Street Area (2.64), the Central Intermediate School Area (1.67), Alapai (1.45), Kauluwela (1.43), and Waikiki-Kalia (1.38). The lowest rates, next to Schofield Barracks, were found in Pacific Heights-Dowsett (0.34), McCully-Kapahulu (0.36), and Alewa-Puunui-Nuuanu (0.38). Complete information for the various census tracts is given in Table 1.

It is apparent that the persons in most imminent danger of commitment to Territorial Hospital tend to cluster in the central business district and nearby transitional areas. The only important exceptions for the 1948-1952 period were Waikiki, a recreational area with a resident population consisting

* The authors gratefully acknowledge the cooperation of the director and staff of Territorial Hospital and the clerical assistance of Fannie L. Lum of the Honolulu Redevelopment Agency.

[1] Schmitt, R. C.: Housing, Health, and Social Breakdown on Oahu: a Study of Census Tract Statistics. Honolulu, Honolulu Redevelopment Agency, September, 1954.

[2] Faris, R. E. L., and Dunham, H. W.: Mental Disorders in Urban Areas, Chicago, University of Chicago Press, 1939.

[3] Clausen, J. A., and Kohn, M. L.: The Ecological Approach in Social Psychiatry. Am. J. Sociol. 50:140 (Sept.) 1954. See also H. Warren Dunham, "Comment," *ibid.*, pp. 149-151, and John A. Clausen and Melvin L. Kohn, "Rejoinder," *ibid.*, p. 151.

[4] Compiled from annual reports of the Department of Institutions, 1947-1948, 1949-1950, and 1951-1952, and annual reports of Territorial Hospital for 1948-1949 and 1950-1951.

TABLE 1.—*First Admissions to Territorial Hospital, for the Island of Oahu: January 1, 1948 to December 31, 1952.*

CENSUS TRACT	LOCATION	NUMBER	RATE
Oahu		258.8	0.78
Honolulu		193.6	0.81
1	Moanalua-Kahauiki	7.0	0.52
2	Kalihi-Kai	8.2	0.88
3	Kalihi-Uka	15.4	0.91
4	Waiakamilo	3.2	0.78
5	Iwilei-Sand Island	4.2	0.89
6	Kapalama	7.6	0.69
7	Palama	3.6	0.76
8	Kauluwela	11.2	1.43
9	River Street Area	11.6	2.64
10	Lanakila-Kunawai	5.2	0.75
11	Alewa-Puunui-Nuuanu	2.4	0.38
12	Central Business District	5.8	3.15
13	Central Intermediate School Area	6.8	1.67
14	Kakaako	4.4	1.09
15	Alapai	6.6	1.45
16	Punchbowl-Pauoa	6.4	0.64
17	Pacific Heights-Dowsett	1.0	0.34
18	Kewalo-Pawaa	4.8	0.52
19	Lower Makiki	4.2	0.94
20	Makiki Heights	5.2	0.73
21	Tantalus-Manoa	9.0	0.71
22	Waikiki-Kalia	15.0	1.38
23	McCully-Kapahulu	3.6	0.36
24	Moiliili-Punahou	7.2	0.74
25	Kapahulu-Diamond Head	7.2	0.59
26	Kaimuki (ewa part)	4.8	0.55
27	Kaimuki (koko head part)	4.4	0.69
28	St. Louis Heights-Palolo-Wilhelmina Rise	10.0	0.49
29	Waialae-Kahala-Koko Head	7.6	0.67
Other Oahu		57.4	0.67
30	Kailua-Lanikai-Waimanalo	8.6	0.78
31	Kaneohe-Kualoa	5.0	0.60
32	Kaaawa-Laie	2.6	0.95
33	Kahuku-Paumalu	2.0	0.87
34	Helemano-Haleiwa-Kawailoa	2.6	1.07
35	Waialua-Mokuleia	3.6	0.68
36	Wahiawa	6.2	0.64
37	Schofield Barracks	0.2	0.07
38	Waianae-Nanakuli	5.2	0.78
39	Barbers Point—Ewa	5.8	0.83
40	Waipahu	4.4	0.48
41	Pearl City-Waiau	3.4	0.62
42	Aiea-Halawa-Pearl Harbor	7.8	0.59
Not reported		4.8	.....

chiefly of highly mobile, unattached persons in the middle income groups, and Helemano-Haleiwa-Kawailoa, a rural district populated mostly by plantation workers.

The geographical distribution of mental disorder rates tends to coincide with the distribution of similar rates for housing deficiencies, mortality, morbidity, and various kinds of social breakdown. The degree of such coincidence is revealed by the high coefficients of correlation computed between the mental illness rates described above and the fifteen related series compiled for the Redevelopment Agency study.[5] These coefficients of correlation, based on 1948-1952 data for the forty-two Oahu census tracts, are listed in Table 2.

[5] Robert C. Schmitt, *ibid.*

TABLE 2.—*Coefficients of Correlation Between First Admission Rates to Territorial Hospital and Various Other Rates, Oahu, 1948-1952.*

RELATED VARIABLE	r
Housing	
Dilapidation	.529
Overcrowding	.514
Health	
All deaths	.800
Infant deaths	.336
Suicides	.233
Tuberculosis	.756
Venereal disease	.868
Social breakdown	
Illegitimate births	.592
Unemployment	.529
Couples without own household	.325
Families under $2,000 income	.349
Adults under 5 years schooling	.312
Widowed or divorced persons	.591
Juvenile offenders	.494
Admissions to Oahu Prison	.729

It should be emphasized that, although a high degree of correlation indicates geographic association of two given variables, and thus presents important clues to the character of the areas in question, it does not constitute proof of a causative relationship. Most authorities would agree, for example, that mental illness is more directly linked to suicide deaths than to tuberculosis morbidity, yet the correlation coefficient was much lower in the former case than in the latter.

The foregoing findings should prove useful to public health officials, social agencies, and private physicians. They indicate the geographic areas where the mental health problem is most acute on Oahu, and thus where preventive measures are most needed. These findings also reveal that the neighborhoods with the highest degree of mental breakdown also tend to have the highest crude death rates, tuberculosis morbidity rates, venereal disease rates, and admission rates to Oahu Prison. Similarly, geographic areas with low admission rates to Territorial Hospital will be correspondingly low in other indices of health and well-being.

It is to be hoped that future research probes far beyond the limits necessarily set for the present study. Hawaii provides a unique laboratory for the study of mental illness, whether by ecological techniques or otherwise. Such analysis is urgently needed.

Honolulu Redevelopment Agency
Honolulu Hale 13, Honolulu, Hawaii

Woman's Auxiliary

In Memoriam—Mrs. William H. Stevens

We shall miss her . . . Eileen Stevens, who served as Recording Secretary and Vice-President in the Honolulu County Auxiliary; Eileen who personified graciousness and willingness.

A few weeks before her passing, we visited over the telephone. Her statement about Auxiliary participation, I would like to share with you.

Said Eileen, "The Auxiliary has given me so much . . . an opportunity to meet, to work with, and to know so many more women than I would ordinarily. I enjoy being a part of the group."

Membership Meeting Specials

The March Auxiliary meeting in Honolulu featured Dr. Carleton Green, Professor of English at the University of Hawaii, reviewing books that make up a well-balanced reading diet.

The pot-luck luncheon and social hour provided an added attraction which drew an unusually good attendance of members and friends, who not only enjoyed an entertaining speaker but also good food contributed by the members.

Annual Convention—Hawaii Academy of General Practice

The annual convention of the Hawaii Academy of General Practice and the Invitational Scientific Congress had the wholehearted cooperation of both the Territorial and the Honolulu County Auxiliaries.

The ladies manned the information desk, provided transportation, and spent hours decorating the banquet hall. To these many ladies who so graciously made the convention a success, we say "Thank you!"

Thursday, April 7, 1955 was "G.P." day. The men were on the golf course while the ladies attended the Pacific area fashion show and luncheon held at Queen's Surf. In the evening at the American Chinese Club, cocktails followed by the Ten Course Mandarin Dinner and the "Life and Loves of a Mandarin" completed the evening.

Starring in the "Life and Loves of a Mandarin," a repeat performance, were:

Mandarin	Dr. Robert Faus
First Wife	Mrs. Samuel Yee
Second Wife	Mrs. Thomas Chang
Third Wife	Mrs. Theodore Tomita
Fourth Wife	Mrs. Chew Mung Lum
Fifth Wife	Mrs. Edmund Ing
Children	Teena Hong, Steven and David Lum
Maid	Mrs. George Tyau
Music	Mrs. Edmund Lee
Backstage	Mrs. Raymond Yap
	Mrs. Kenneth Ho
Costumes	Dr. Abe Ng Kamsat
	Mrs. Raymond Kong
	Mrs. Lau Tang
Producer	Mrs. H. G. Pang
Script and Commentator	Mrs. Joseph Lam

Auxiliary chairmen for the Convention were:

Registration	Mrs. John Devereux
Auxiliary Co-Chairmen	Mrs. Robert Millard
	Mrs. Homer Benson
Banquet	Mrs. H. Q. Pang
Fashion Show and Luncheon	Mrs. Howard Liljestrand

Medical Family Roller Skating Party

Monday, April 11, 1955, from 7:30 to 11:00 p.m. the Woman's Auxiliary to the Honolulu County Medical Society sponsored a Benefit Skating Party at Rainbow Rollerland.

This first benefit we hope will initiate a series of money-making projects aimed at raising enough funds to purchase a piano for the Mabel Smyth lounge.

Mrs. Fred Gilbert was chairman of the committee composed of Mrs. Satoru Nishijima, Mrs. Harold Kimata, and Mrs. K. S. Tom.

The Budget and Fund Raising Committee that is planning this series of events is under the chairmanship of Mrs. K. S. Tom.

Mrs. Joseph W. Lam

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Recent Acquisitions

Biochemistry

Holley, H. L. *Potassium metabolism in health and disease.* c1955. (gift of publisher)

Prigogine, I. *Introduction to thermodynamics of irreversible processes.* c1955. (gift of publisher)

Ragan, Charles, ed. *Connective tissues. Trans. . . . 5th conf., Feb. 8-10, 1954, Princeton, N. J.* c1954. (gift of Josiah Macy, Jr. Foundation)

Blood

Allen, E. V. *Peripheral vascular disease.* 2nd ed. c1955. (gift of publisher)

Cartwright, G. E. *Diagnostic laboratory hematology.* c1954. (gift of publisher)

Dreguss, M. N. *Experimental studies in equine infectious anemia.* c1954. (gift of Grayson Foundation)

Tocantins, L. M., ed. *The coagulation of blood.* c1955. (gift of publisher)

Cancer

American Cancer Society *Proceedings . . . 2nd national cancer conference, 1952.* In 2 v. c1954.

Armed Forces Institute of Pathology *Atlas of tumor pathology.* Sect. 2, Fasc. 5; Sect. 4, Fasc. 11; Sect. 6, Fasc. 21; Sect. 6, Fasc. 23 and 24. 1953-54 (gift of Armed Forces Institute of Pathology)

Communicable Diseases

Hull, T. G. *Diseases transmitted from animals to man.* 4th ed. 1955. (gift of publisher)

Endocrinology

Ralli, E. P., ed. *Adrenal cortex. Trans. . . . 5th conf., Nov. 4-6, 1953, Princeton, N. J.* c1954. (gift of Josiah Macy, Jr. Foundation)

Selye, Hans *Third annual report on stress.* 1953. (gift of publisher)

Geriatrics

Donahue, Wilma, ed. *Growing in the older years.* c1951. (from Nurses' Association)

Donahue, Wilma, ed. *Planning the older years.* c1950. (from Nurses' Association)

Gynecology and Obstetrics

Calkins, L. A. *Normal labor.* c1955.(gift of publisher)

Fish, J. S. *Hemorrhage of late pregnancy.* c1955. (gift of publisher)

Medicine

Emerson, C. P. *Essentials of medicine.* 17th ed. c1955. (from Nurses' Association)

Harrison, T. R., ed. *Principles of internal medicine.* 2nd ed. In 2 v. c1954. (from Board of Medical Examiners)

Neurology and Psychiatry

McAuley, W. F. *The concept of schizophrenia.* 1954. (gift of publisher)

Michaels, J. J. *Disorders of character.* c1955. (gift of publisher)

Singer, Marcus *The human brain in sagittal section.* c1954. (gift of publisher)

Wilson, S. A. K. *Neurology.* 2nd ed. In 3 v. 1955. (from Board of Medical Examiners)

Nursing

Eliason, E. L. *Surgical nursing.* 10th ed. c1955. (from Nurses' Association)

McAllister, J. B. *Ethics: with special applications to the medical and nursing professions.* 2nd ed. c1955. (from Nurses' Association)

Ophthalmology

Corbett, M. D. *How to improve your sight.* Rev. ed. c1953. (gift of Louise Keown)

Duke-Elder, Sir Stewart *Textbook of ophthalmology.* v. 7. 1954.

Pediatrics

Levine, S. Z., ed. *Advances in pediatrics.* v. 6 and v. 7. c1953-55. (from Board of Medical Examiners)

Therapeutics

Conn, H. F., ed. *Current therapy, 1955.* c1955. (gift of publisher)

Goodman, L. S. *The pharmacological basis of therapeutics.* 2nd ed. c1955. (from the Board of Medical Examiners)

Modell, Walter, ed. *Drugs in current use, 1955.* c1955. (gift of publisher)

Year book of drug therapy, 1953-54 series. c1954. (gift of Dr. deHay)

Miscellaneous

Burke, R. M. *An historical chronology of tuberculosis.* 2nd ed. c1955. (gift of publisher)

Samter, Max, ed. *Regional allergy of the United States, Canada, Mexico, and Cuba.* c1955. (gift of publisher)

Shaw, J. H. *Fluoridation as a public health measure.* c1954.

Tripler Army Hospital, Dept. of Surgery *Symposium on trauma.* 1955. (gift of Tripler Army Hospital)

* * * *

After compiling our statistics for the annual report, we were pleased to see that the library collection is not only growing steadily, but that its use by our members is increasing every year. Since a library's value can only be measured by the use which is made of its facilities, it is gratifying to know that there is an awakening appreciation of and demand for its resources and services.

Mrs. Florence Gray resigned in February to return to the mainland. We were sorry to lose her valuable services in the Library and wish her success in her new work.

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Book Reviews

Handbook of Medical Treatment.

Edited by Milton J. Chatton, M.D., Sheldon Margen, M.D., and Henry D. Brainerd, M.D., Fourth Edition, 569 pp., Price $3.00, Lange Medical Publication, 1954.

This is the fourth almost-annual edition of this handy compendium on medical therapy. The handbook contains ready reference tables of all kinds. The simplified approach to medical diseases from the therapeutic standpoint makes this book a valuable adjunct to any physician's library. It covers the field from physical medicine to diseases of the skin and from fluid electrolyte therapy to diseases of unknown etiology.

It is true of this edition as of other handbooks from this publisher, that this book is not intended to substitute for the more detailed and standard texts on therapy. It is to be used as a handy and quick reference for the busy physician who wants an authoritative source of information that he can carry in his medical bag or in his coat pocket. I recommend it highly and consider it especially valuable for the general practitioner who already has so much other literature to cover.

MORTON E. BERK, M.D.

Concept of Schizophrenia.

By W. F. McAuley, M.D., 145 pp., Price $3.75, Philosophical Library, 1954.

Here are 139 pages filled with meaningful quotations and views of many authors, with a brief consideration of the usual factors considered in the genesis of schizophrenia. Chapters are short; the author's views are often unstated; and definite conclusions are rarely drawn.

The style was not interesting to me and though some of the views presented are challenging the book does not meaningfully argue them.

It seemed to me a major error that no mention was made of electroconvulsive therapy of schizophrenia, in view of its widespread use.

The analytic bent of the author, coupled with the utter lack of coverage of the important work recently done by psychoanalysts with schizophrenics, completed my disappointment.

JAMES G. HARRISON, M.D.

The Human Brain in Sagittal Section.

By Marcus Singer, Ph.D., and Paul I. Yakovlev, M.D., 81 pp., illustrated, Price $7.75, Charles C. Thomas, 1954.

This work is an atlas in the unconventional sagittal plane. The authors agree, and with some justification, that the course of the major fiber tracts of the brain is in the cephalocaudal direction. This work is an attempt to make for better understanding of three-dimensional relationships.

The value of the work lies in the excellent reproductions, the care in labelling and measurements of sections from the midline so one can maintain orientation. The work is highly recommended for those interested in three-dimensional neuro-anatomy.

JOHN J. LOWREY, M.D.

Textbook of Physiology.

Edited by John F. Fulton, M.D., Seventeenth Edition, 1,275 pp., illustrated, Price $13.50, W. B. Saunders Company, 1955.

It is really impossible to discuss this textbook adequately in a short review and it seems certainly not necessary to recommend it specially. Seventeen editions in the course of 50 years speak for themselves. As the Dutch proverb says: "Good wine needs no crown," and this book is excellent, one of the very best in its field the world over. The entirely rewritten first section (7 chapters) on nerve and spinal reflex activity is impressive in that it presents the old, and particularly the new, in a masterly way. But all other sections are also brought up to date, presenting and discussing critically the latest new ideas. The references at the end of each chapter make the book more valuable still, so that it can be used not only as a textbook, but also as a reference book.

It may be considered as a "must" in the personal library of every physiologist, be he interested in human, general or even comparative physiology.

P. B. VAN WEEL, Ph.D.

The Coagulation of Blood.

Edited by Leandro M. Tocantins, M.D., 240 pp., Price $5.75, Grune & Stratton, Inc., 1955.

A few years ago coagulation of blood was a simple process, and all "bleeders" had hemophilia. Now, with the advent of AHG, PTC, PTA and a myriad other components, coagulation belongs to the specialist and hemophilia has become many diseases.

This volume is intended as a guide to certain standard tests and procedures in this field. To accomplish this, members of a panel, chosen for recognized abilities, present in concise form the simple as well as the complicated tests necessary to evaluate the diagnosis of "hemophilia."

I suggest that this book belongs in all laboratories as an excellent manual, and in the libraries of the physicians particularly interested in coagulation of blood.

LEON E. MERMOD, M.D.

Fundamentals of Clinical Orthopedics.

By Peter A. Casagrande, M.D., and Harold M. Frost, Jr., M.D., 582 pp., Price $18.50, Grune & Stratton, Inc., 1953.

The accumulation of material on the basic sciences as related to the musculo-skeletal system into one volume, with correlation of clinical syndromes, makes this book a very welcome addition to the orthopedic literature. It is carefully written and presents ideas and opinions of numerous authors in a most logical fashion. It should be of tremendous value and interest to students of orthopedics, particularly residents, interns and the busy practitioner who needs a ready reference book without too much detail on any one particular subject.

IVAR J. LARSEN, M.D.

The Management of Pain.

By John J. Bonica, M.D., 1533 pp., illustrated, Price $20.00, Lea & Febiger, 1953.

In spite of this book's unwieldy size, it is a most valuable one. It will be bought by few physicians, but it should be on the shelf of every medical library of any size. It is made exceptionally useful for reference by its excellent double columned index of almost thirty pages and with the detailed table of contents of eight pages, supplemented by an explanatory preface (which incidentally must be read) the publication is of great value.

The author might have gone even further with the subject by dividing pain into normal and pathological types.

Many will argue that this book should have been published in three separate volumes—each one containing the three major divisions: Part I "Fundamental Considerations," Part II "Management of Pain" and Part III "Pain Syndromes." If this had been done, however, the original idea of the author in having the entire subject in one volume would have been lost. The reviewer is of the opinion that the author of this publication has made a most valuable contribution to medical literature and that its size will not be too much of a handicap to its being frequently consulted, if not extensively read.

J. Warren White, M.D.

Correlative Neurosurgery.

By Edgar A. Kahn, M.D., Robert C. Bassett, M.D., Richard C. Schneider, M.D., and Elizabeth Caroline Crosby, Ph.D., Sc.D., 413 pp., Price $19.50, Charles C. Thomas, 1954.

"Correlated Neurosurgery" is a reflection of the opinions and experiences of the neurosurgical group at the University of Michigan. No attempt has been made to cover the whole field of neurosurgery, but rather a specific group of common problems as seen by the neurosurgeons is discussed. This book will be of some interest to the neurosurgeon, and will probably be helpful to the first and second year residents in neurosurgery. It has little to offer to other physicians. This book contains discussions concerning a group of neurosurgical problems which has been adequately covered in other volumes on many occasions.

Donald R. Simmons, Major, MC

Diabetes Mellitus.

By Henry T. Ricketts, M.D., 123 pp., Price $3.25, Charles C. Thomas, 1955.

This monograph by Henry T. Ricketts covers the subject well. He tells in a very practical way how to estimate insulin dosage and diet. One thing he emphasizes is the need for the diabetic to have a really thorough physical examination to check on the serious complications such as pulmonary tuberculosis, infections of the female genitourinary tract, and cataract and and heart disease.

Dr. Ricketts emphasizes the importance of educating patients so they will best avoid the complications that beset them, and so they can live long and useful lives. This book would be a welcome addition to one's library.

Teru Togasaki, M.D.

Disorders of Character.

By Joseph J. Michaels, M.D., 148 pp., Price $4.75, Charles C. Thomas, 1955.

One of the few books in the much neglected field of psychiatric research, this is a good addition to the literature on the problems of "psychopathic personality." The author focuses attention on the symptom of persistent enuresis as being a marked characteristic of the lack of control shown in psychopathic individuals. He states, "Persistent enuresis reflects the general diffuse pattern of the inability to control impulses which permeates the whole personality of the psychopath." Especially interesting and very informative are the chapters on Bio-Psycho-Social Interpretations of Persistent Enuresis, Delinquency and Psychopathy, and Disorders of Character. Dr. Michaels attacks the problem from almost every aspect with emphasis on the psychoanalytical point of view. There is a good review of literature with sound constructive criticism of the psychiatric confusion concerning the dynamic and structural theory of character. This is a good book to read in learning more about the behavior of people.

H. Joseph Simon, M.D.

Diseases Transmitted from Animals to Man.

By Thomas G. Hull, Ph.D., 717 pp., illustrated, Price $12.50, Charles C. Thomas, 1955.

This is a very useful reference for physicians and veterinarians. It is a little out of date in spots, as it is a symposium of 24 contributors. Only hematophagous bats are considered as rabies carriers, and there is no reference to its presence in bats in the United States. The latest reference on Q Fever is 1946. There are very few misspellings and "typos."

The arrangement is excellent, with "Items of Note" in a few paragraphs, setting forth the chief points brought out in each chapter. At the end, each animal is mentioned and the transmitted diseases for which it is responsible, and an alphabetical arrangement of diseases and common hosts, which is valuable.

It is stated, however, that anthrax is more or less prevalent in Hawaii, and also that psittacosis was reported from Honolulu in 1929-30 (the two cases were non-residents).

The statement that tetanus spores are destroyed by direct sunlight is denied by some experts.

This book can be recommended as a good reference on animal-borne diseases of man.

James R. Enright, M.D.

Hemorrhage of Late Pregnancy.

By John S. Fish, M.D., F.A.C.S., 180 pp., illustrated, Price $5.50, Charles C. Thomas, 1955.

This book on hemorrhage of late pregnancy deals with the various aspects of premature separation, abruptio, and marginal sinus rupture. Placental pathology is interestingly presented.

The importance of this book lies in the fact that the hitherto dormant knowledge of marginal sinus rupture as a cause of late pregnancy hemorrhage is thoroughly analyzed. It is interesting to find that over one-third of all late hemorrhages are due to this condition.

Those interested in obstetrics would welcome this addition to their library.

Satoru Nishijima, M.D.

Normal Labor.

By Leroy A. Calkins, M.D., 128 pp., Price $4.00, Charles C. Thomas, 1955.

This most recent unit of the American Lecture Series in Gynecology and Obstetrics is composed of random reflections on normal labor. It contains conclusions cybernetically determined by the punch-card tabulation of 16,000 delivery records. It samples the theories of the etiology of the onset, and the physiology of the course, of the process. Considerations covering the stages, the puerperium, analgesia and anesthesia, along with a summary and appendices, complete the effort.

Surprisingly enough, forceps extraction of the fetus is included as part of the management of "normal" labor, despite the fact that such intrusion upon the mechanism certainly suggests scant faith in the natural provisions for the function.

The bulk of the work consists of the appendices, each of which is the reprint of an article or paper previously presented. Most of them are already familiar to the qualified obstetrician from his regular perusal of the principle periodicals of his specialty, but they can be scrutinized by anyone to his advantage for their emphasis on careful management of the third stage to prevent dangerous blood loss.

Suggested as a library reference for quick availability of the author's papers.

LYLE BACHMAN, M.D.

The Management of Mental Deficiency in Children.

By I. Newton Kugelmass, M.D., 312 pp., illustrated, Price $6.75, Grune & Stratton, Inc., 1954.

Recently, much interest has been centered on the problems of mentally retarded children. The present approach is that all defectives can be trained, some can be educated, and most can be prepared for a useful life endeavor. This volume, written especially for doctors, helps bring order to the large number of heterogenous disorders related only by the common denominator of incomplete or inadequate mental development. The author offers easy methods of arriving at accurate diagnoses based on signs and symptoms, and there is included a classified group of syndromes observed in everyday practice. The section on the management of the retarded child is of great value to those who will have occasion to advise parents on this great medical problem.

PERSHING S. LO, M.D.

Reactions with Drug Therapy.

By Harry L. Alexander, M.D., 301 pp., illustrated, Price $7.50, W. B. Saunders Company, 1955.

This book gives a brief and well organized discussion of the reactions seen when using the more common drugs, hormones, serums and some vehicles and adjuvants.

An early chapter deals with the discussion of mechanisms by which these drugs may produce reactions. In the latter chapters the drugs are discussed individually or in groups when possible and a brief summary of the types of reactions and treatment is presented.

This book will serve as a good review at the present time when so many more new drugs, especially antibiotics, are being produced and more mild and fatal reactions are being reported.

GEORGE H. MILLS, M.D.

Christopher's Minor Surgery.

Edited by Alton Ochsner, M.D., and Michael E. DeBakey, M.D., Seventh Edition, 547 pp., illustrated, Price $9.00, W. B. Saunders Company, 1955.

Ochsner and DeBakey have produced a practical, readable, entirely new, small volume on minor surgery which will be of value chiefly to the house surgeon and general practitioner. As indicated in their preface, the distinction between minor and major surgery is but a degree of "potential threat to life," but "jeopardy to life," however small, carries "the highest degree of responsibility." With this in view twenty-one surgeons from the Tulane and Baylor schools have written a book which probably will be very popular for some time to come. This volume is extremely practical and full of information which only comes with adequate experience of the proper kind. It covers practically all branches of surgery.

A certain amount of provincialism is to be expected in a work of this nature where experiences of one group of workers will form the basis of discussion on various topics. But this is offset by the fact that the volume reflects the experiences of a competent group of progressive surgeons.

The chief weakness of the volume lies in repetitions in different chapters (in some instances three or more times), e.g., malignant melanoma, sebaceous cysts, epithelioma and others. Nothing is gained by such repetition. Halsted is mis-spelled "Halstead." The suggestion that an endocrine factor may be concerned in the picture of pilonidal sinus is far-fetched. Linton probably would not find indications, even rarely, for sympathectomy in post-phlebitic syndromes. However, these defects are small compared with the greater worth of the volume as a whole.

SHOYEI YAMAUCHI, M.D.

The Joints of the Extremities.

By Raymond M. Lewis, M.D., 108 pp., illustrated, Price $8.50, Charles C. Thomas, 1955.

This valuable and informative monograph will be of interest primarily to orthopedists and radiologists. It is by no means a text book but primarily demonstrates some of the less common and less well known pathologic conditions involving the joints of the extremities. The author stresses particularly the various inflammations and other conditions involving the peri-articular soft tissues.

The material is well arranged and the book abounds with excellent radiographic illustrations accompanied by very well written captions. I am sure that this will prove to be a valuable reference book for anyone interested in diseases involving the peripheral joints.

RICHARD D. MOORE, M.D.

Abdominal Operations.

By Rodney Maingot, F.R.C.S., Eng., Third Edition, 1580 pp., illustrated, Price $24.50, Appleton-Century-Crofts, Inc., 1955.

Maingot's third edition adds some 300 pages to his monumental 1948 edition, with important new contributions by 15 British and American surgeons. Also added is an excellent chapter on *The Investigation of the Jaundiced Patient,* contributed by an American internist.

(Continued on Page 447)

Bureau of Medical Economics

What goes on in your front office?

Day after day you enter your office, and things I am sure, appear normal to you. Yes, that pile of ragged magazines doesn't even catch your conscious eye, nor do the dirty hand prints on the wall, or the many other small things that make your office untidy, unpleasant and even dirty. But to your regular patients these very things light up like a bright light and to the patients who are entering your office for the first time they light up like a ball of fire from an atomic bomb. (I am sure that there is no need of a reminder of how important first impressions are.)

Today, when you enter your office, look around. Look around, and take a look at what your patients see. Remember that here is where they sit and WAIT—*wait* and *look* and *observe*. Why don't you even take some time to sit down in one of your chairs and *look* and *observe*. Now, are you satisfied with what you have just seen?

We spoke a minute ago about first impressions, and now along with that thought I would like you to take a minute to reminisce about that account that mail had been returned on, and you have now given up hope of ever finding the patient. Now really stop reading and start thinking back about it. . . .

I am sure you were able to recall one to mind. Well, let us assume that his first impression of your office was satisfactory . . . but did your nurse or receptionist get complete records on the patient? What I am trying to say here again is—"What goes on in your front office?"

Complete records are essential to follow-up collections, consequently it is most important to obtain full information from patients on their first visit if possible. It is neither unprofessional nor too time-consuming to obtain credit information from patients. In about sixty seconds a doctor or his secretary can ask a few questions which make possible a shrewd appraisal of a patient's over-all ability to pay. Here is the type of information that should be obtained:

1. Record patient's full name, correctly spelled. Just J. A. Lee is not sufficient—John Allen Lee would be more helpful for identification. If the full name is not recorded it may be impossible to locate the patient, J. A. Lee, in later collection follow-ups.
2. Find out the name of the person to be billed as well as the relationship to the patient, i.e., wife treated, husband billed.
3. Determine marital status and number of dependents. When couples are divorced or separated, *credit and collections become complicated*. For example, inquire of a woman whether the bill should be sent to her husband at such and such an address.
4. Request present address, do not accept a P. O. Box number. The neighborhood he lives in may give you some indication of his financial status.
5. Obtain job details. If a man says he works at American Factors, find out not only what department but whether he is a shipping clerk, salesman or vice-president.
6. Ask who recommended him. It would be wise when referring a patient to another doctor to send along credit information or data regarding the patient's approximate ability to pay.
7. Where a substantial fee is involved, some physicians inquire as tactfully as possible of the patient, approximate annual income and financial responsibility in order to set an equitable fee.
8. Don't be taken in by superficial signs of prosperity. A patient who appears to be rolling in money may owe bills all over town.

One more thing about your front office that I think is extremely important. How does your receptionist treat your waiting patients? Of all the complaints that we have heard from a doctor's office it is the prolonged unexplained waiting periods that seem to bother patients the most.

Your receptionist must be trained to handle the waiting patients. When a patient first enters the office they should be told of the approximate waiting period, (this is of utmost importance) and the receptionist should make a notation of the time she has told the patient to wait. When the time comes and a further delay is indicated then the patient should be tactfully told of the delay with a word of apology. If a prolonged period of waiting becomes necessary, then the reason for the delay should be explained to the waiting patient. A patient who clearly understands how long he must sit and wait, will sit back and relax until his time is up, but after his expected time is up I am sure that his blood pressure will rise from a base point squared by the minutes of delay and divided by the age of the magazine he or she is reading. (If the patient is a mother with a child, multiply the answer by ten.) Last, but certainly not least, be certain that the waiting patient understands why a patient that came in after he or she did gets to see the doctor first. If this is not explained the blood pressure again starts the spiral staircase, but because of the complicated formula for arriving at the base point, we will omit it from this article.

In conclusion let us say that you should observe the goings-on in your front office. A great deal of your new patients come to you upon the recommendation of an old patient and next to the results of your treatment of them are the results of your front office, on whether or not you will get their nod of approval when asked for a recommendation.

R. M. KENNEDY
Executive Secretary

HMSA—Its Place in the Community

Accomplishments in 1954

J. R. VELTMANN, *General Manager*

HMSA held its Seventeenth Annual Membership Meeting at Queen's Surf on March 25, 1955, at 12:00 noon. The meeting was attended by 185 individuals representing 24,500 members of the Association. At this annual meeting operations of the year are reviewed and new directors are elected for a two-year term. The following physicians were elected to serve for the period 1955-57. Dr. Rodney T. West (re-elected), Dr. John Bell and Dr. Toru Nishigaya representing the Honolulu County Medical Society; Dr. George Tomoguchi and Dr. Archie Orenstein (Alternate) representing the Hawaii County Medical Society; Dr. Edward B. Underwood and Dr. A. Y. Wong (Alternate re-elected), representing the Maui County Medical Society; and Dr. Sam R. Wallis and Dr. Burt O. Wade (Alternate) representing the Kauai County Medical Society. Holdover Directors representing the Honolulu County Medical Society are Dr. Edwin K. Chung-Hoon, Dr. Laurence M. Wiig and Dr. Samuel L. Yee.

In reporting on the activities of 1954, Mr. Howard Babbitt, HMSA President, pointed out that HMSA enjoys broad acceptance by the people of Hawaii after 16 years of continued community service. He noted a net gain of 14,602 members during the year, bringing the total membership to 86,535 at the end of the year. The greatest amount of benefits in the history of HMSA was paid out in 1954. Of the $2,073,020.00 paid in benefits, $1,285,272.00 was paid to doctors and $747,478.00 to hospitals for services rendered to HMSA members. These amounts represent a return of over 85¢ out of each dues dollar and it is the sixth consecutive year that HMSA has returned over 81¢ of every dues dollar to its members in the form of benefits.

He stated that HMSA's dedication to the principle of community service was demonstrated in achieving the lowest operating cost ratio in the history of the plan—10.7% of dues income, which is 1.1% less than our 1953 operations and represents a reduction of 7% during the last four years. HMSA now has adequate general reserve funds to cover at least 3 months of incurred liabilities to meet contingencies.

In 1954 HMSA turned its attention to better public relations with members, participating physicians and hospitals. For members the Association began with increased benefits effective January 1, 1954. The most popular was the removal of restrictions in connection with surgery and hospitalization for surgery for chronic and pre-existing conditions. For doctors, hospitals and their staff, a series of Educational Seminars were planned and conducted to keep them informed on national and local trends in the field of prepaid medical care and to facilitate prompt payment of all claims submitted for payment. Quarterly progress reports which explained changes in business operations, provided instructions for claims procedure and other important HMSA facts were provided doctors and hospitals also.

Having gained financial and administrative stability, HMSA began to consider necessary means to meet the challenging demands for greater medical coverage for its members. As part of the answer, HMSA has been selected by the medical profession to offer the public a Community Group Medical Plan designed by physicians to offer a broad scope of benefits. This plan will be available in the very near future. To answer the many requests for protection against catastrophic illnesses, HMSA has developed a Major Medical Expense Program which will be offered as additional coverage to HMSA basic coverage. In brief, the plan covers 75% of all doctor, hospital and other medical costs up to $5,000.00 after all eligible benefits of the basic plan have been used and payment of a minimal co-insurance factor by the member. HMSA will be offering this type of coverage for the first time. It is not reinsured through a commercial company, nor is it to be subsidized by government funds—it is HMSA's own plan. The plan will be announced simultaneously with the Community Group Medical Plan, but could be added as a "Rider" to HMSA's basic Comprehensive Plan or Plan I, with a slight adjustment in rates. It will be available only to groups with HMSA basic plan coverage and all underwriting regulations of the basic plan would apply. Both the employee and his dependents are eligible for this protection.

In his annual report, the General Manager of HMSA reviewed several charts and graphs depicting the growth of HMSA in the past seven years. He noted that membership in the plan had increased 160% since 1948, and pointed out that during 1954, 93,332 doctor and hospital claims were processed, compared to 44,651 processed in 1950.

He attributed progress made by HMSA during the past year to the excellent "teamwork" among the Board of Directors, the staff, physicians, hospitals and members. He emphasized the importance of continued "teamwork" particularly in view of the two new programs which become effective during 1955, and indicated that cooperative efforts would result in two things —more benefits to members and more of the doctor's services covered at no increased monthly dues.

HMSA looks forward to continually improving its services to the public and hopes to attain a membership of over 100,000 by the end of 1955.

County Society Reports

Honolulu

The regular monthly meeting of the Honolulu County Medical Society was held Tuesday, March 1, 1955 at 7:30 P.M. in the Mabel Smyth Auditorium. Dr. R. C. Durant presided and approximately 103 members and guests were present.

An excellent scientific program which included topics of interest to all was as follows:

"Newer Methods of Diagnosis in Urology"
by Dr. Benjamin S. Abeshouse
"Surgical Planing of the Skin for Acne Scars and Other Defects"
by Dr. Harold M. Johnson
"Current Legislative Proposals Affecting Physicians"
by Dr. Roy E. Brown, Director
Tax Foundation of Hawaii

The business meeting commenced with the approval of the minutes of the membership meeting held February 1, 1955 and the Special membership meeting held February 15, 1955.

Drs. Clifford Chock and Norman R. Sloan were welcomed into the Society as new members. Col. John W. Raulston was welcomed in as an associate member.

A copy of the Honolulu County Medical Library Budget was circularized to the membership for their approval and was unanimously accepted. Amendments to the Constitution and By-Laws of the Honolulu County Medical Library, a copy of which had been mailed to each member, were brought up for approval and it was moved, seconded and carried that they be adopted.

A letter written by Dr. Thomas S. Bennett regarding a Territory-wide poliomyelitis vaccine program for 1955 was read by the president. Special emphasis was made that the vaccine would be handled by volunteer physicians and that a resume of the letter just read, with a questionnaire asking for volunteers, would go out in the next Board of Governors Bulletin.

A report of the Medical Practice Committee regarding the resolution introduced by Dr. R. Ando at the February 1 membership meeting and referred to this committee was read by the president. Dr. Ando stated that the Medical Practice Committee had expressed what he had hoped they would. After some discussion, it was moved by Dr. Dickson and duly seconded that the resolution be tabled indefinitely. The motion carried.

Announcements were made by Dr. Quisenberry who reminded the membership of the first Dr. Grover Batten memorial lectures to be held March 7 through 9, 17 and 18 and would be delivered by Dr. Lauren V. Ackerman, these lectures to be presented through the auspices of the Hawaii Medical Association in cooperation with the Hawaii Cancer Society.

Dr. John Devereux reviewed the program of the Invitational Scientific Congress of the Hawaii Territorial Academy of General Practice to be held April 5 through 9.

Dr. Faus reported 67.7% practicing doctors (212 out of 313) have signed affirmative answers to the participating physicians agreement of the new Community Group Medical Plan. A minimum of 85% was necessary before this plan could be offered by HMSA.

There being no further business the meeting adjourned to the lanai for refreshments.

* * *

The regular monthly meeting of the Honolulu County Medical Society was held Tuesday, April 5, 1955 at 7:30 P.M. in the Mabel Smyth Auditorium. Dr. R. C. Durant presided and approximately 107 members and guests were present. The guests present included a number of visiting doctors here for the Invitational Scientific Congress of the Hawaii Territorial Academy of General Practice.

For the scientific session a very interesting presentation was given by Dr. Arthur de Graff of New York City on "The Present Status of Digitalis and the Cardiac Glycosides."

The minutes of the previous meeting were approved as read.

Drs. Verne Lonell Brechner and Le Roy P. W. Froetscher were welcomed into the Society as new regular and associate members respectively.

An election of the Library Board of Directors was held and the annual reports of the Library Board of Governors and Library Committee were read.

Incomplete election to break the tie for alternate delegate to the HMA between Dr. Edmund Lee and Dr. Thomas Min was held. Voting was done by secret ballot and Dr. Lee was elected.

A standardized insurance claim form for all medical claims except HMSA and Workmen's Compensation, representing many hours of work by the insurance carriers and Mr. R. M. Kennedy, was presented to the membership for approval. Mr. Kennedy was called upon to discuss the form in detail. A motion was entertained by the Chair to accept this form and it was moved, seconded and carried that this insurance claim form be accepted by the Medical Society.

A plea was made for more volunteer doctors to help with the Polio Vaccine Program which is tentatively scheduled to begin April 21, 1955.

House Bill 662, which would require three years' residence in the Territory for licensure, was brought before the membership for an expression of opinion. This matter was first brought to the attention of the Legislative Committee, and inasmuch as it was requested by local doctors the committee felt the voice of the membership should be heard on the subject. After a brief discussion it was moved by Dr. Henry and duly seconded that the Legislative Committee be empowered to actively oppose the bill. The motion carried unanimously.

Dr. Rodney West presented an interim report on current doings of HMSA. He touched briefly on the net membership gain during the past month, new enrollments, operations, and mentioned the names of the newly elected directors of HMSA. He also announced that 90.2% of the practicing physicians have signed the participating physicians agreement for the new Community Health Plan and that HMSA is now ready to start the plan going as soon as the x-ray and laboratory fee schedule had been settled.

In direct relation to the abovementioned x-ray and

laboratory fee schedule, Dr. T. H. Richert stated that in view of the fact that there will be no membership meeting scheduled for next month, and since this fee schedule is fairly close to being right, that the Society should vote the power to the Board of Governors to accept or review the recommendations of the Fee Adjustment Committee with respect to the Community Group Medical Plan in order to facilitate its presentation to the community. This recommendation was put into the form of a motion by Dr. Frederick Giles and was duly seconded.

Dr. Henry moved that the Board of Governors be empowered to act without coming back to the Society, if they reach an agreement with the various minority groups involved. The president quoted from the Constitution and By-Laws the duties and powers of the Fee Adjustment Committee and ruled that this particular motion was out of order for the following reasons: (1) That a letter from the Society has been directed to HMSA to proceed with the selling of the plan providing they felt the percentage of physicians signed up warranted the selling of the plan. That we have an established fee schedule in effect at the present time covering x-ray and laboratory fee schedules and there is nothing to prevent HMSA from selling this plan now. (2) There was not sufficient representation here this evening. The entire membership should have a chance to voice their opinions in the matter. Dr. Henry contested the ruling of the chair with the statement that he knew of no fee schedule covering the various x-ray and diagnostic fee schedules. Considerable pro and con discussion followed, culminated by a motion made by Dr. Clarence Y. Sugihara who moved that the membership postpone this question indefinitely. The motion was duly seconded and carried with twelve dissenting votes.

There being no further business the meeting adjourned to the lanai for refreshments.

T. NISHIGAYA, M. D.
Secretary

Maui

A program meeting of the Maui County Medical Society was held on Sunday morning, February 20, 1955 at the Central Maui Memorial Hospital. Present were: Doctors H. Kushi, Rockett, Fleming, Shimokawa, Tompkins, Wong, Haywood, McArthur, Sanders, Underwood, Totherow, Otsuka, Patterson and Izumi. Guests present were: Doctors J. W. Cherry and Boyd.

Dr. Reppun's question regarding lowering the dues of outside island doctors was discussed. It was moved by Dr. Haywood, seconded by Dr. Totherow that dues for outside island doctors remain the same. This passed unanimously.

Dr. Cherry from Honolulu presented an excellent discussion on abdominal injuries.

* * *

The regular dinner meeting of the Maui County Medical Society was held at the Central Maui Memorial Hospital on Tuesday, March 15, 1955.

Dr. Underwood reported that the new HMSA plan was expected to start on the outer islands as of April 1, 1955. Dr. Tompkins moved that we accept April 1, 1955 for the institution of this new plan. This was seconded by Dr. Sanders and passed unanimously.

It was agreed that Dr. Ferkany will appoint various local physicians to speak to the Maui service clubs on Cancer.

Dr. Quisenberry, Executive Director of the Hawaii Cancer Society, introduced Dr. Ackerman, who presented a very interesting discussion on Pathology.

* * *

A special meeting of the Maui County Medical Society was called to order at 7:30 P.M. at Central Maui Memorial Hospital on Tuesday, April 5, 1955.

A letter from Dr. Larsen, President of the Hawaii Medical Association, requesting our cooperation in the giving of the Salk vaccine was read. Dr. Underwood moved that we approve the Salk vaccination plan and administration by volunteer physicians in principle. This was seconded by Dr. McArthur and passed unanimously.

(Continued on Page 455)

Coconut Grove Hotel

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Correspondence

To the Editor:

Our attention has been called to an item on page 226 of the January-February, 1955 issue of the Hawaii Medical Journal under the heading "Hawaii Gets the Nod!"

The article implies that Hawaii Medical Service Association is described for the first time in the 1954 edition of Voluntary Prepayment Medical Benefit Plans. This particular pamphlet was published initially in 1946. It has been revised annually since then and Hawaii Medical Service Association has been included in all the issues.

The article further implies that the Health Insurance Plan of Greater New York (popularly known as H. I. P.) is not included in the publication. H. I. P. was described for the first time in the 1948 revision of the brochure and has been included in each subsequent revision. This plan, however, is in a separate section of the brochure which includes those plans which are either affiliated with or sold in connection with Blue Cross plans which are not approved by medical societies.

The Ross-Loos program was described initially in the 1948 brochure and has been included in each subsequent revision. Ross-Loos is included in another section of the pamphlet since that program has been approved by the Los Angeles County Medical Association.

Perhaps the non-inclusion of descriptions of Kaiser Health Foundation plans is more attributable to lack of definite information than other reasons which may be suspected. There are so many seemingly interlocking arrangements that it is most difficult to isolate any health benefit program and develop an accurate description. It is possible that credible information may be sometime developed with respect to the health program specifically. Whether or not it may be included in future revisions of the brochure will depend on the attitudes of the Committee on Prepayment Medical and Hospital Service and the Council on Medical Service.

We offer the above in the interest of contributing to more complete reporting of programs which have been published over a period of years.

Howard O. Brower
Assistant Secretary
American Medical Association

Feb. 17, 1955.

Umi Makahiki I Hala*

Dr. Raymond G. Nebelung, Doctor of Public Health, formerly a member of the faculty of the School of Hygiene and Public Health at the University of Michigan, where he received his training, and subsequently at Oregon State University, was recently appointed Executive Director of the Public Health Committee of the Chamber of Commerce of Honolulu.

* * *

It has recently been announced by **Dr. F. J. Pinkerton,** chairman of Procurement and Assignment for the Territory of Hawaii, that 15 physicians from the Territory have entered the Army or Navy medical corps since February 1944 and approximately 15 more of our local doctors will enter the services during the next few weeks.

Recent additions to the staff of internes at The Queen's Hospital were **Dr. Nyla Ruth Elnes** and **Dr. Grace Hall Hedgcock,** both of Women's Medical College of Pennsylvania, who came to work here April 10, 1945.

Dr. and Mrs. Guy C. Milnor are traveling on the mainland and expect to return to Honolulu about September 1. At that time they will bring their son **John** with them to serve his internship at the Queen's Hospital. He will graduate on June 20 from Temple University.

Dr. and Mrs. Robert Wong of Honolulu welcomed the arrival of their first child on May 11. The baby is named Stephen Willis Wong and weighed 7 pounds 9 ounces at birth.

* Ten years ago. From Volume 4, Number 5, May-June, 1945.

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Notes and News

DOCTORS

Honored . . .

. . . by the Republic of Korea

The Korean Order of Military Merit of Taegu was presented to **Colonel Louis K. Mantell,** Chief of Urology Service at Tripler Army Hospital. The medal was accompanied by a certificate which was signed by the Republic of Korea President Syngman Rhee.

. . . by the Department of Health

Dr. Herbert T. Rothwell of Kahuku received a certificate of appreciation for a quarter of a century of service. The Honolulu County Medical Society and Dr. Rothwell's scores of friends join Dr. Richard K. C. Lee in extending deep appreciation to Dr. Rothwell for his years of hard work and enviable record of long and real devotion to duty.

. . . by the Kailua Junior Chamber of Commerce

Dr. Robert C. H. Chung was named outstanding young man of 1954, for Windward Oahu. Dr. Chung is a graduate of the Pacific Union College and the College of Medical Evangelists. He is the Territorial and City and County physician for Kailua, Lanikai, and Waimanalo. He is a director of the Kailua Business Group and the Windward Rotary Club, and Medical Director for Civilian Defense in Kailua. He is Health Chairman of the Executive Committee of the Windward Oahu Community Association. Dr. Chung is also a member of Kailua Junior Chamber of Commerce, the Kailua Community Association, the Kailua Seventh Day Adventist Church, and the Board of the Kailua Mission School. He is Chairman of the Hospital Committee for the Windward Oahu Community.

Elected . . .

. . . to Fellowship by the American College of Radiology

was **Dr. Louis L. Buzaid,** Director of Radiology at Queen's Hospital. Dr. Buzaid is a graduate of Temple University School of Medicine. He received his training in Radiology at Jefferson University Medical School and at the University of Pennsylvania.

. . . to membership in the Honolulu County Medical Society

Dr. Clifford Koon Y. Chock is a graduate of Temple University School of Medicine. He served his internship at St. Luke's Hospital at Bethlehem, Pennsylvania and a two years' residency at the Allegheny General Hospital at Pittsburgh, Pennsylvania. Dr. Chock is a member of the American Society of Anaesthesiologists. He is in the private practice of anesthesiology and may be reached at his home.

Dr. Norman R. Sloan first became a member of this Society in 1941. He spent 10 years at Kalaupapa Settlement. He left Hawaii in 1950. From 1952 to 1954, he worked with the South Pacific Commission on Hansen's Disease and traveled throughout the Pacific islands. Dr. Sloan rejoined the Board of Health in 1955 as Assistant Chief of the Board of Venereal Disease and Cancer.

. . . pro tem Chairman of the American Legion Post-Convention tour

Dr. Philip M. Corboy, Hawaii member of the National Executive Committee of the Legion. The tour is scheduled for September 1956. It is expected to bring 5,000 to 8,000 American Legion members to Hawaii.

. . . to the Executive Board of the Adventurers Club

Dr. Clarence Fronk and **Dr. Howard Liljestrand.**

. . . Officers of the Hawaii Territorial Academy of General Practice

President: **Dr. John W. Devereux**
Vice President: **Dr. H. Q. Pang**
Secretary-Treasurer: **Dr. Robert Katsuki**

. . . Directors of the Honolulu Council of Social Agencies

Dr. Katherine J. Edgar and **Dr. Leslie Vasconcellos.**

. . . President of the Hawaii Heart Association

Dr. Morton Berk.

New City and County Physician

Dr. David Katsuki has been confirmed by unanimous vote of the Board of Supervisors of the City and County of Honolulu for this position, succeeding **Dr. Thomas Mossman.**

New Anesthesiologist

is **Dr. Verne L. Brechner.** Dr. Brechner is a graduate of the Washington University School of Medicine. He interned at Seaside Memorial Hospital, Long Beach, California. He spent 2 years on the staff of Leahi Hospital and 2 years as resident anesthesiologist at the University of California Hospital in San Francisco. Dr. Brechner is married and has a 4 month old son.

New Psychiatrists

Dr. E. W. Haertig has been appointed Director of the Division of Mental Hygiene of the Territorial Department of Health. Dr. Haertig is a graduate of the University of Chicago. He interned and had a year of psychiatric residency at St. Elizabeth Hospital, Washington, D. C. He also had a residency in psychiatry at the Sheppard-Pratt Hospital in Towson, Maryland. Previous to his arrival in Hawaii, Dr. Haertig was in private practice of psychiatry for 8 years in the state of Washington. In Seattle, he was a lecturer at the Psycho-Analytical Training Center.

Dr. Leon Miller now serves as child psychiatrist with the Bureau of Mental Hygiene of the Department of Health. Dr. Miller is a graduate of Yale University School of Medicine. He interned at St. Vincent's Hospital, Jacksonville, Florida. He served a year's residency at the Cottage Hospital, Santa Barbara, Florida. He received his psychiatric training at the Massachusetts General Hospital.

New Chairman

Dr. Masato Hasegawa has been named Acting Chairman of the Territorial Commission on Children and Youth.

New Internist

The Straub Clinic announces the addition of **Dr. Frank J. Bruce.** Dr. Bruce is a graduate of Wayne University School of Medicine. He interned at Gorgas Hospital, Canal Zone. He served a year's residency at Sacred Hearts OCD Hospital in Honolulu. Following this, he practiced general medicine in Honolulu for 5 years. He then took 3 years' residency training in internal medicine at the Peoples Hospital in Akron, Ohio.

New Intern

Dr. Hidetaka Segawa joined the house staff of Kuakini Hospital. Dr. Segawa graduated from Keio University School of Medicine, Tokyo, Japan. He served a year's internship and a year's surgical assistantship at Keio University Hospital.

New Office . . .

. . . in Waikiki

Dr. Serge Ross announces the opening of his office for the general practice of medicine at 305 Royal Hawaiian Avenue. Since coming to Hawaii in 1952, Dr. Ross has been associated with the Kahuku, Waialua, and Southshore hospitals. Recently, he served as part-time physician with the Rehabilitation Center of Hawaii.

. . . old timer

Dr. H. Joseph Simon returned after 2 years of military service and resumed the practice of psychiatry at 1415 Kalakaua Avenue.

. . . in Honolulu

Dr. George H. Nip announces the removal of his offices to 246 Young Hotel Building with practice limited to surgery.

. . . in Kailua

Dr. Samuel C. Y. Lui announces his return from military service and the resumption of his practice at 444 Ulunui Street, Kailua.

. . . where?

Dr. Thomas Mossman is interested in a suitable location for the private practice of general medicine. He may be contacted at 6-9088.

New Babies

Dr. and Mrs. Isaac Kawasaki are the parents of a girl, Kay, born November 25, 1954.

Dr. and Mrs. William Ito announce the birth of a daughter, Della Ann, born September 15, 1954.

Dr. and Mrs. Richard Lam announce the birth of a daughter Suzanne on February 3.

Dr. and Mrs. Fugate Carty are the parents of a son Timothy, born January 26.

Dr. and Mrs. Duke Choy announce the birth of a daughter on April 3.

Mrs. James Detor, formerly secretary of the Honolulu County Medical Society, is the proud mother of a baby boy, James Nicholas, born on February 16, 1955.

United in Matrimony

Dr. Robert Kimmich, Medical Director of the Territorial Hospital, Kaneohe, and Miss Jean Sumi Yamauchi were married on March 11 at the Pilgrim Chapel of Central Union Church.

Dr. Thomas S. Bennett, neurosurgeon, and Miss Margaret Hind Clark pledged their vows on March 26.

Dr. Michael Minoru Morisaki wed Miss Helen Hieda of New York in a nuptial mass at St. Patrick Cathedral in New York earlier this year. Dr. Morisaki graduated from Marquette University and the University of Michigan Medical School. He is presently interning at Mt. Sinai Hospital, New York. After his internship he will be a fellow at the Mayo Foundation.

Licensed to Practice Medicine in Hawaii

Drs. Gilbert A. Ching, William T. Boyar, Clifford Chock, E. B. Helms, L. J. Perry, N. Shklov, L. G. Van Loon, and **Stanley Wong.**

Travelers . . .

. . . to Philadelphia

Dr. Nils P. Larsen acted as one of the moderators in a symposium on "Stress and Aging" sponsored by the American College of Physicians. During this meeting Dr. Larsen also delivered a talk on Hawaiian folklore.

. . . to Philadelphia and Mexico

Dr. Alfred Hartwell also attended the meeting of the American College of Physicians. While away, Dr. Hartwell visited Mexico City, Cuernavaca, Taxco, and other places of interest in Mexico.

. . . to Houston, Philadelphia, and Atlantic City

Dr. Joseph Strode attended the meetings of the American Thoracic Association and the American Surgical Association.

. . . to Philadelphia, Atlantic City, and Oklahoma City

Dr. Gilbert Freeman attended the meetings of the American Surgical Association, The American Association of Thoracic Surgeons, and the American Gastric Association.

. . . to Washington, D. C., Banff, and Lake Louise

Dr. and Mrs. Peter Washko left for an extended trip to the mainland and Canada in April. Dr. Washko attended the meetings of the American Radium Society and Inter-American Congress of Radiology in Washington, D. C. He also participated in a course given by the Atomic Energy Commission and the Cook County Hospital on radioactive isotopes. Before returning to Honolulu, he will tour the northwestern portion of the United States and the Canadian Rockies.

. . . to Los Angeles and New York

Dr. Martin Lichter attended the annual meeting of the American Academy of General Practice in Los Angeles.

. . . on European tour

are **Dr. and Mrs. H. L. Arnold, Sr.,** accompanied by their daughter, Mrs. Robert Lowrey.

. . . to Mexico

Dr. Richard W. You was one of the physician trainers who accompanied American athletes to the Pan American Games in Mexico.

Addressed . . .

. . . the Adventurers Club of Honolulu

Dr. Alvin V. Majoska spoke on a three and a half month voyage to the South Pacific on the yacht Chiriqui.

His film and lecture included experiences in the Society and Gambier Islands, Pitcairn Island, Easter Island, The Galapagos, and Panama.

. . . the Parent Teachers Association of Central Intermediate School

Dr. E. W. Haertig discussed some preventable factors in juvenile delinquency. Dr. Haertig also addressed the first annual convention of the Oahu Counselors Association on the importance of teamwork in the diagnosis and treatment of problem children.

. . . the Hui Hauoli Club

Dr. James G. Harrison, psychiatrist, showed movies and answered questions on Meeting Emotional Needs of Children at a meeting of the Hui Hauoli.

. . . the Central YMCA Health and Strength Club

Dr. Richard W. You was the keynote speaker at the first meeting of this newly formed group.

. . . the National Airport Group in Arlington, Virginia, and the Political Study Group in Washington, D. C.

Dr. You Chan Yang, Korean Ambassador to the United States, spoke on the tense situation in the Far East particularly as it affects Formosa.

. . . the Reserve Officers Association ladies

Dr. Lyle G. Philips' subject was Communism in Hawaii. Dr. Philips also reviewed 7 years of obstetrics at Kapiolani Maternity Hospital before the Hawaii Academy of General Practice.

. . . the Hawaii Academy of General Practice

Dr. John Felix spoke on Afribrinogenemia in Pregnancy.

Old Office . . .

. . . full time

Dr. Thomas Y. K. Chang, a physician of the City's Health Department for the past 7 years, resigned to devote full time to private practice.

Dr. Raymond deHay is now practicing in Kailua full time with practice limited to internal medicine.

Kauai News

Dr. and Mrs. Patrick Cockett and family left March 26 for an extended trip to the Mainland and Mexico. While on the trip Dr. Cockett will attend the Conventions of the Academy of General Practitioners, Los Angeles, California; Industrial Medical Association, Buffalo, New York; and American Medical Association, Atlantic City, New Jersey.

NEWS

Industrial Medicine Course

A full-time eight-week comprehensive course in industrial medicine for physicians will be given in the Post-Graduate Medical School of New York University-Bellevue Medical Center commencing Monday, September 26, 1955, it was announced by Dr. Norton Nelson, director of the Institute of Industrial Medicine.

Among the subjects being offered to physicians are: organization, administration, and economics of an industrial medical department; the practice of preventive and constructive medicine in industry; the clinical aspects of occupational diseases; industrial injuries and the elements of safety programs; toxicology and industrial hygiene for the physician. Opportunities will be provided for attendance at medical, surgical and clinical pathological conferences during the course.

Applications should be sent to the Dean, NYU Post-Graduate Medical School, New York 16, N. Y. Tuition $250.

Ophthalmologists to Meet in Santiago, Chile, in 1956

Ophthalmologists of the Western Hemisphere will assemble for the Fifth Pan American Congress of Ophthalmology in Santiago, Chile, January 9 to 14, 1956, under the presidency of Dr. Moacyr E. Alvaro, of Sao Paulo, Brazil.

There are two secretaries: for countries north of Panama, the secretary is Dr. Thomas D. Allen, Chicago (Dr. Daniel Snydacker, 109 North Wabash Avenue, Chicago, is acting secretary at present), and for countries south of Panama, Dr. Jorge Balza, Buenos Aires.

Doctor Wanted

General practitioner in Honolulu suburban practice looking for appropriate associate. If interested, please get in touch with Mrs. Bennett at the Hawaii Medical Association.

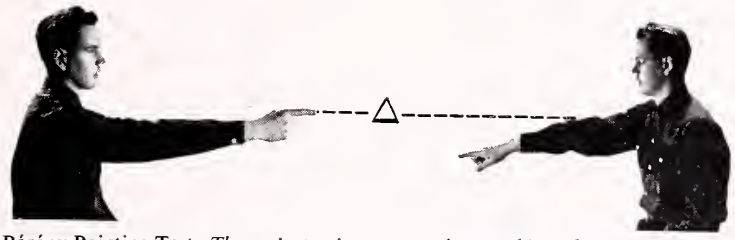
Nine Doctors and God

Mr. Thomas Nickerson, chairman of the University of Hawaii Press, announces that a new edition of Dr. F. J. Halford's *Nine Doctors and God* will be published early in May. This edition will contain an additional photograph—that of the Reverend Hiram Bingham—and a reproduction of one of the public notices posted during the 1853 smallpox epidemic, conscripting citizens to help bury the dead.



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1. Bárány Pointing Test. *The patient points at a stationary object, first with his eyes open and then closed. A constant error in pointing (past pointing) with his eyes closed in the presence of vertigo indicates peripheral labyrinthine disease or an intracranial lesion.*



2. The Caloric (Bárány) Test. *The patient sits with his eyes fixed on a stationary object and the external ear canal is irrigated with hot (110 to 120 F.) or cold (68 F.) water. If the vestibular nerve or labyrinth is destroyed, nystagmus is not produced on testing the diseased side.*

3. The Rotation (swivel chair) Test. *The patient sits in a swivel chair with his eyes closed and his head on a level plane. The chair is turned through ten complete revolutions in twenty seconds. Stimulation of a normal labyrinth will cause nystagmus, past pointing of the arms and subjective vertigo.*



Notes on the Diagnosis and Management of "Dizziness"

I. Vertigo

The term "dizziness" (vertigo) should be restricted to the sensation of whirling or a sense of motion.[1] This sensation is usually of organic origin and is the tangible symptom of a specific pathology.

Moderate vertigo, with a sense of motion and a whirling sensation, may be produced by infection, trauma or allergy of the external or middle ear. Examination of the ear will usually disclose the abnormality.

Severe vertigo, which will not permit the patient to stand and causes nausea and vomiting, indicates an irritation or destruction of the labyrinth. The specific condition may be labyrinthine hydrops, an acute toxic infection, hemorrhage or venospasm of the labyrinth or a fracture of the labyrinth. Multiple sclerosis and pathology of the brain stem should be considered also.

It is important to learn if the patient's sensation is continuous or paroxysmal.[2] Paroxysmal vertigo suggests specific conditions: Ménière's syndrome, cardiac disease and epilepsy. Continuous vertigo without a pattern may be due to severe anemia, posterior fossa tumor or eye muscle imbalance.

Dramamine® has been found invaluable in many of these conditions. In mild or moderate vertigo it often allows the patient to remain ambulatory. A most satisfactory treatment regimen for severe "dizziness" is bedrest, mild sedation and the regular administration of Dramamine.

Dramamine is also a standard for the management of motion sickness, is useful for relief of nausea and vomiting of radiation sickness, eye surgery and fenestration procedures.

Dramamine (brand of dimenhydrinate) is supplied in tablets (50 mg.) and liquid (12.5 mg. in each 4 cc.). G. D. Searle & Co., Research in the Service of Medicine.

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1. Swartout, R., III, and Gunther, K.: "Dizziness:" Vertigo and Syncope, GP *8*:35 (Nov.) 1953.

2. DeWeese, D. D.: Symposium: Medical Management of Dizziness: The Importance of Accurate Diagnosis, Tr. Am. Acad. Ophth. *58*:694 (Sept.-Oct.) 1954.

SEARLE

A Summary of Recent Research*

Wine in Modern Medical Practice

> "...in response to the demand within the medical profession that the true values or deficiencies of wine be ascertained, that there be a clear separation of fact from folklore, and that there be an impartial analysis and study of those features which can be scientifically measured...."*

a series of independently conducted research programs has been in progress for many years under the sponsorship of the Wine Advisory Board of California.

Some of the most important new research findings have been incorporated in a small brochure* specifically written for the medical profession. The booklet considers the role of wine in the treatment of the convalescent and the geriatric patient, as well as its use in the specialized fields of gastroenterology, cardiology, urology, etc. There is mention, too, of the psychobiologic effects of wine, such as its capacity to add a touch of interest and "elegance" to restricted or special dietaries.

A copy* is available to you, at no expense, by writing to:

Wine Advisory Board, 717 Market Street, San Francisco 3, California.

*"Uses of Wine in Medical Practice"

INTER-ISLAND NURSES' BULLETIN

Official Publication of the Nurses' Association, Territory of Hawaii

LEONA R. ADAM, *Executive Secretary,* Honolulu

BULLETIN COMMITTEE

NORA SHIROMA, *Editor,* Honolulu

KAREN TANAKA, *Chairman, Nursing Information Committee,* Honolulu

EMILY KAAUA, Hawaii — SALLY NAKANO, Honolulu

MIYOKO MASUNAGA, Kauai — ALICE TAGAMI, Honolulu

LAURA WONG, Maui

LILA CHUN, *Student, St. Francis School of Nursing*

PRESIDENT'S MESSAGE

During the past two months, the efforts of the Nurses' Association have been concentrated on studying and supporting desirable legislation for the Territory of Hawaii and on working out a satisfactory financial pattern for the Nurses' Association itself. Under the leadership of Miss Margaret Barnett of Hawaii, a small special finance committee spent many hours reviewing reports and discussing possible ways of meeting the deficit. This has been a very difficult task. It is not easy to decrease costs and at the same time maintain the standards that have made our Association an organization of which we can be justly proud. If more graduates realized that the Nurses' Association not only had a great deal to offer them professionally and personally but that individual nurses could fulfill more readily their obligation to participate in efforts to improve the health of our nation by belonging to the Nurses' Association, our financial problems would be greatly lessened. It does not seem fair for less than half of the nurses in Hawaii to support the operation of an organization dedicated to the improvement of nursing practice and the welfare of all nurses in the Territory. However, when compared with records in other state nurses' associations, our percentage of membership is considered quite good. The Board of Directors considered the recommendations of the special finance committee at its meeting on April 1. All members of the association can be of assistance in this matter by promoting membership and by actively participating in the program of the organization.

All nurses are urged to prepare themselves as well as possible for disaster nursing and to give wholehearted support to local and Territorial plans for civilian defense. God grant that there will be no disaster but if there should be, it would indeed be unfortunate if we were caught napping.

SISTER MARY ALBERT, R.N., O.S.F.

CULTURAL BELIEFS AND PRACTICES OF THE CHILDBEARING PERIOD AND THEIR IMPLICATIONS FOR NURSING PRACTICE —(Continued)

(In this condensed version, only the beliefs and practices still existing among women of childbearing age are given. A knowledge of beliefs, fears and taboos associated with childbirth may provide a basis for greater understanding on the part of doctors and nurses during a woman's pregnancy and delivery.)

Chinese Beliefs and Practices

Still a belief among younger women interviewed is that the woman is, in some way, responsible for a defective child. A stillbirth, premature birth or a defective or birthmarked child is looked upon as a punishment for wrongdoing. Beliefs still held include that looking on ugly animals, or pounding nails, or moving furniture about during pregnancy, may result in cord strangulation. Avoiding the subject of deformities was held as a preventive measure by some of the women.

In general, the Hawaiian-born Chinese group believed in modern concepts of prenatal care and hygiene. There was general agreement that a hospital was the best place to have a baby, though one woman preferred the home where she could give birth in a squatting position.

The Hawaii Health Messenger, Vol. XVI, No. 2, February 1955.

Two beliefs were found in the younger group that were not discussed by the older women. One is that the infant's eyes could be washed with a pint of honeysuckle flower water which was also good for him to drink. The other was that the healing of the navel was helped by the application of a mixture of ashes from black cloth which came from China and a hen's stomach lining.

Two rural women believed in the contraceptive effect of herb teas and said they knew of certain herb extracts which would induce abortion. Some belief still existed that fruits and vegetables were a weakening diet in the postpartal period. Most of the group believed a modern, balanced diet was desirable during pregnancy. There were individual notions that vinegar harmed the baby, chicken soup with whiskey had a tonic effect, cold foods caused miscarriage by making the blood flow, and the tentacles of a squid, if eaten, would hold the baby back at delivery time. Two women avoided cold foods and vegetables the first month after delivery and one believed she would lose her milk if she burned foods while frying them.

The umbilical cord is still kept by several women as a good luck piece for the child's future. These same women believed that the placenta should be buried deep in the ground so harm would not befall the infant.

Belief that a postpartal woman is unclean and that female blood is contaminated was more general. Statements were "the mother is unclean for 100 days" . . . "take a large black pill for three days to cleanse the uterus of nine months' dirt" . . . "the mother's chopsticks and dishes should be kept separate from the rest of the family for 30 days" . . . "a mother should not nurse while she is menstruating."

While little was found in present practices that is really harmful to maternal and child health, the interviews showed in general two things: When a child is born with defects or even prematurely, the idea that it is the mother's sole responsibility puts an unusual burden of guilt feelings upon her and deprives her of the helpful effect of shared responsibility. Secondly, beliefs in evil spirits gave additional fear to the natural anxiety of giving birth experienced by all women.

(To be continued)

ANA HONORS EXECUTIVE SECRETARY

Miss Ella Best, R.N., Executive Secretary of the American Nurses' Association, was honored for 25 years of service to the association at a dinner given by the ANA Board of Directors, January 22, in the Hotel Plaza, New York.

Miss Best has visited almost all of the 54 ANA constituencies since she became executive secretary in 1946. She was a special guest at the annual meeting in Honolulu in 1952. When she joined the staff as field secretary in 1930, ANA membership was 87,036, and there were ten staff members at headquarters. As executive secretary, she now administers the work of 92 staff members, and association membership has grown to more than 175,000.

A graduate of St. Luke's Hospital School of Nursing in Chicago, she later taught there as well as in Miami Valley Hospital, Dayton, Ohio, and the Michael Reese Hospital, Chicago. She also was assistant to the dean of the Cook County School of Nursing, Chicago. She served as president of the First District, Illinois State Nurses' Association, and as secretary of the ISNA before coming to ANA headquarters.

Miss Best has attended congresses of the International Council of Nurses in Atlantic City and Brazil, as well as ICN Board of Directors' meetings in Brussels and London. In 1949, she was present for the ICN's 50th anniversary conference in Stockholm. Also in that year, she was invited as a speaker to the International Hospital Federation's First International Congress in Amsterdam. She is currently chairman of the ICN's Public Relations Committee.

OAHU NEWS

Aloha and best wishes to Miss Karen Tanaka, Assistant Director in Nursing Education, St. Francis Hospital School of Nursing, who is leaving to enroll at the University of Washington in Seattle. She hopes to complete further studies towards her Master's Degree in Nursing Education.

We are going to miss you, Karen!

Meet Our Student Nurses in Hawaii

The students of four schools of nursing presented a wonderful program on April 4, 1955 for the Nurses' Association, District of Oahu.

Mrs. M. Johnson, acting president of Student Council, introduced the program: F Major on Parade, The Doe Family versus Tuberculosis, Meet the "Shadows" and Variety Dancing.

The students of St. Francis Hospital, University of Hawaii, Kuakini Hospital and Queen's are credited for presenting an enjoyable evening for the many nurses who were present.

NEWS FROM KAUAI

Mr. and Mrs. Allen Michioka announced the birth of their first child, Blaine Shigeo, on February 24. Mrs. Michioka, the former Hilda Nemoto, is on leave of absence from the Samuel Mahelona Memorial Hospital.

Friends of Miss Lillian Chong, formerly of the Samuel Mahelona Memorial Hospital, will be happy to learn that she is settled in her new position with the Children's Rehabilitation Institute in Reisterstown, Maryland. Her mailing address is 122 Slade Avenue, Pikesville, Maryland.

MYRNA CAMPBELL, R.N.

NEWS FROM MAUI

The year 1955 started off with a bang. Membership renewals have been encouraging. Maui aims to meet her quota.

The annual dinner meeting was held at the Puunene Club House with fifty in attendance. New officers were installed. Miss Elizabeth Morishige, President, presented her annual report in grand style. She used a colorful graph which showed the activities of the past year and a message of challenge for 1955.

General and executive board meetings were each held monthly. This association has been concerned with the financial situation of NATH. Several meetings were held to consider this situation with suggestions for a solution of the problem. Mrs. Alexander represented Maui at the Special Budget Committee meeting held in Honolulu in February.

The membership is considering ways and means of raising funds for sending delegates to the convention to be held on Kauai this year. Many of the members are interested in going.

There has been a series of educational institutes sponsored by various agencies which were open to the nurses. Many took advantage of this opportunity for professional improvement.

Mrs. R. Suzuki and Mrs. Helen Goshi from Central Maui Memorial Hospital attended the Polio Institute in Honolulu sponsored by N.F.I.P. On their return, they, together with Miss T. Fallon, Orthopedic Nursing Consultant, National League for Nursing, presented a series of institutes at the different hospitals.

Institute on Exceptional Children*

The Institute on Exceptional Children held at the Central Maui Memorial Hospital on February 28 and March 1 was attended by public health nurses, teachers, social workers and other professional and interested people. This institute was sponsored by the Maui Easter Seal Society of which W. James Tozer is the president.

Entitled "A New Look at the Exceptional Child with Realistic Goals and Limitations," the new idea of treating a handicapped child as a whole child was thoroughly explored. A team approach was utilized with the nurse, social medical worker, psychologist, teacher, and the physiotherapist.

Group from Honolulu were: Mrs. Mapuana McComas, Executive Director of the Hawaii Society; Dr. Charlotte Florine, member of the Medical Advisory Board of the Oahu Society for Crippled Children and Adults; Mrs. Elizabeth Uchiyama, teacher in charge at the Sultan School for Handicapped Children; Dr. Sidney L. Halperin, Bureau of Mental Hygiene; Miss Theresa Fallon, Orthopedic Nursing Consultant of the National League for Nursing; Mrs. Elsa McKrell, Physiotherapist of Sultan School.

The Maui participants were: Mrs. Laura Wong, Department of Health; Miss Harriet Suzuki, Department of Public Instruction; Mr. Henry Kono, Bureau of Sight Conservation and Work with the Blind; Mr. Kenneth Watanabe, psychiatric social worker with Maui Department of Health; Mrs. Okuni Tanner, public health nurse; Miss Lieselotte Meyer, Maui Crippled Children's Society; Mr. G. Fred Bush, Jr., an active member of the Board of Directors of the Maui Society.

* Mrs. Okuni Tanner, Maui Public Health Information Committee.

Institute on Geriatrics†

"Growing old is no more than a bad habit which a busy man has no time to form" by French writer, Andre Maurois.

Recently an Institute on Geriatrics was sponsored by the Business and Professional Women's Club in cooperation with the Department of Health and the Hawaii Cancer Society. The purpose of the Institute was to plan to meet the needs, utilize the abilities and develop potentialities of the aging population of Maui. The consensus was that an immediate survey should be made to determine health problems of the aging, available housing facilities, and what older people want to do.

Dr. Walter Quisenberry, Executive Director of the Hawaii Cancer Society, discussed the physical, mental and emotional aspects. The Maui leaders covered the medical and social services, old age and survivors insurance, aid to the aged, housing, spiritual resources, adult education and recreational resources.

Mrs. Gloria W. Foster, public health nurse and Health and Safety Committee Chairman of the Business and Professional Women's Club, was the chairman. On the planning committee were: Mrs. Margaret Alexander, Assistant Supervisor, Public Health Nursing; Mrs. Okuni Tanner, public health nurse; Mrs. Gloria Foster.

This was the first program of this kind to be held on Maui and was attended by 85 persons.

LAURA D. WONG, R.N.

NEWS AND BITS—PUBLIC HEALTH NURSES' SECTION

The public health nurses of the Department of Health have recently completed in-service education on relaxation and good body mechanics. Classes were conducted on Oahu, Hawaii, Kauai and Maui by Miss Leona Rubbelke, Maternal Health Nursing Consultant of the Department of Health; Mrs. Claire Tearse, Physiotherapist, formerly associated with the San Jose Preparation for Motherhood classes and currently an Army wife in Honolulu; and Miss Mary Neal, Director of Nursing Service of the American Red Cross.

The public health nurses will teach good body mechanics and posture during their home visits and in conjunction with Mother and Baby Care classes.

These classes were also conducted among local hospitals and office nursing staffs to correlate instructions with the latest public health nursing activities. It has been found that many minor discomforts of pregnancy, such as, backache, varicosities, heart burn and painful hemorrhoids, have been relieved by relaxation and good body mechanics.

* * *

Miss Rose Hee, Tuberculosis Nursing Consultant, left the Department of Health in February to join the World Health Organization. After an orientation period in Washington, D. C., she will be assigned to Iran.

Mrs. Vera Rosemond, formerly Chest Clinic Supervisor, has been appointed Tuberculosis Nursing Consultant.

* * *

Mrs. Kazue McLaren was appointed by the Executive Committee of the Public Health Nurses Section, NATH, to be their representative to the ANA Regional Work-

† Mrs. Okuni Tanner.

shop for state nurses' association sections at Los Angeles, California, May 18, 19, and 20.

Problems of the section will be discussed.

KAZUE MCLAREN, R.N.

NATH BOARD MEETING

Friday, April 14, 1955

Committee reports:

a. Nursing Information—Chairman Karen Tanaka
The committee has made plans for publicity throughout the year.

b. Margaret Jones Memorial Fund—Chairman Mrs. Marjorie Elliott
The committee reports that improvements have been made in the investments of the fund. The committee has approved the final payment of $500 on the pledge to the Medical Library endowment fund. They will also repay NATH $500 a year for four years for the part of the pledge unintentionally paid by NATH.

c. Annual meeting — General Chairman Elizabeth Middleton.
To be held on Kauai, September 22-23-24. Plans are moving ahead for a good time on Kauai.

d. Legislation—Chairman Mrs. Myrtle Schattenburg

Action: Approved NATH's support of legislation for water fluoridation.

e. Membership—Chairman Mamie Murakami

f. Inter-island Bulletin — Chairman Mrs. Nora Shiroma

Action: That $15 from "miscellaneous fund" be made available for the committee to use for pictures in the Bulletin.

Action: A special committee was set up to consider featuring a "nurse of the month" for the Bulletin with a possibility of choosing a "nurse of the year" from these.

Action: Because news is no longer news by the time the Bulletin is published, the Bulletin Committee was asked to consider the possibility of sending to the membership a mimeographed news letter in addition to the Bulletin.

g. Mabel Smyth Building — Mrs. Elaine Johnson, Chairman of the Board
The building now has sufficient income to meet its budget which must in the future include certain items for renovation and replacement.

h. Special Committee to Study the NATH Budget—Margaret Barnett
Written report submitted by Elizabeth Middleton, Secretary.
An intensive study of NATH's finances has been made by a committee in each district. Chairmen of these committees have met once in Honolulu.

Action: After consideration of this report, the Board voted to try the office secretary on a half-time basis. Biographies filed with the Counseling and Placement Service will be compiled in the Chicago office. Further changes must be studied in terms of the kind of program the association members wish to support.

Accepted with regret:
Resignation of Lt. Col. Eileen Brady, first vice president. Col. Brady will be stationed in the surgeon general's office in Washington, D. C.
Resignation of Mrs. Grace Page, office secretary, who, with her husband, is returning to the mainland.

Action: Authorized renewal of Oahu Health Council membership. Appointed Winnifred Golley chairman of a special committee to suggest to Oahu Health Council how service clubs may assist the Nurses' Association with projects.

Heard letter from Hawaii League for Nursing stating that they felt there is still a need for the Territorial scholarship for advanced nursing education, but felt that it was not possible to justify it before the legislature. Several scholarships, which are available, have not been used by nurses.

Discussed possibility of holding an institute for nursing service administrators. Action was deferred for further information.

Referred to Nominations Committee a request from ANA for suggestions for nominees for 1956 officers.

It was announced that the following section representatives would attend the ANA regional section workshop to be held in Los Angeles:

Mrs. Edna Baldwin, Industrial
Mrs. Kazue McLaren, Public Health
Mrs. Esther Higuchi, Private Duty
Mrs. Patience Martelon, Nursing Service Administrators

Special Groups, Educational Administrators, Consultants and Teachers, and General Duty Sections had not yet selected representatives.

The Economic Security Committee (section chairmen) met preceding the Board meeting and decided to combine the questionnaires to survey current employment practices for general duty nurses and nursing service administrators. This survey form is to be sent to directors of nursing in all hospitals in the Territory.

The Industrial Nurses Section has sent their survey questionnaire to all industrial nurses.

The Public Health Section has been collecting facts for comparison with existing practices.

With all this activity, we should have some recommended minimum employment standards set up before the end of the year.

AMERICAN NURSES' FOUNDATION, INC.

The American Nurses' Association has formed a membership corporation, the American Nurses' Foundation, Inc., organized exclusively for charitable, scientific, literary and educational purposes.

Agnes Ohlson, R.N., president of the American Nurses' Association, was elected president of the Foundation at the annual meeting of the ANA Board of Directors.

Officers and directors of the Foundation elected are: vice president, Miss Pearl McIver, chief, Public Health Nursing Service, United States Public Health Service, Department of Health, Education and Welfare, Washington, D. C.; secretary-treasurer, Mrs. Elizabeth K. Porter, dean, Frances Payne Bolton School of Nursing, Western Reserve University, Cleveland, Ohio.

The new Foundation was incorporated on January 25 under the laws of the District of Columbia as a membership organization. The Foundation expects to be able to solicit grants and gifts from

the general public and from other charitable organizations with "complete assurance of deductibility thereof for income and estate tax purposes, under Section 501 (c) (3) of the Internal Revenue Code."

The ANA Board of Directors has donated $100,000 to the new corporation to be disbursed during 1955 for studies of nursing functions. These studies have been carried on by the ANA during the past four years and now will continue unchanged under the foundation.

Up until now, the ANA has had to depend entirely on the limited dues from its nurse members to finance such activities as research studies on the functions of nurses, integration of minority groups into professional nursing activities and international nurse exchange programs which are of a distinctly public service.

NLRB REGULATION

The National Labor-Management Relations Act, 1947, requires that ANA certify that copies of the financial report filed with the NLRB have been made available to every member of the Association.

Your cooperation in assisting us to meet the requirements of the National Labor-Management Relations Act is appreciated.

AMERICAN NURSES' ASSOCIATION
2 Park Avenue, New York 16, N. Y.

FINANCIAL STATEMENT

January 1, 1954 - December 31, 1954

Receipts

(1) Dues	$853,695.00
(2) Fees, fines, assessments	none
(3) Other	88,766.12
TOTAL	$942,461.12

Disbursements

(1) Per capita tax, assessments, allawonces	none
(2) Salories	$282,333.90
(3) Toxes (Federal and State)	8,100.24
(4) Other: Program and affice administrotion	512,941.78
Dues to ather orgonizotions	34,339.47
TOTAL	$837,715.39
(5) Total assets ot end of fiscal year (cash, investments, praperty, etc.)	$278,303.79
(6) Tatal liabilities ot end af fiscal yeor	$ 26,756.43

I, duly authorized official of the above-named association, certify that the information submitted herewith is true to the best of my knowledge and belief.

ANNABELLE PETERSEN (signoture)
Treasurer

EXCERPTS FROM REMARKS MADE BY DR. BROCK CHISHOLM, FORMER DIRECTOR GENERAL OF WHO, DURING A STAFF MEETING AT HEADQUARTERS ON 20 JULY, 1953

ED.—*This is apropos, not only to WHO personnel but to everyone of us in our own relations with people.*

There are relatively few people who have the privilege of being important to the whole world. Every single person who is working in WHO is important to all the people in the world, and important not only when he is attending a meeting to represent the World Health Organization or when he is carrying out a specific assignment in a particular field, but important all the time by his attitude, his behavior, by everything he does or says inside and outside the Organization.

The effectiveness of the work of WHO is determined by all this. If any member of the staff gossips about the private behavior of another person, if anybody spends his time figuring out whether someone is better paid than he is, if anyone is concerned for his own prestige instead of the work of the Organization, the World Health Organization, and its value to the people of the world, are being hurt.

This privilege should be regarded as valuable by all of us, and quite unashamedly and without apology, I am going to say something again about maturity. Maturity, like truth, is something that may be moved toward, even approached, though probably never attained in any foreseeable future. The kinds of people that are needed by an organization like WHO, indeed are needed in all organizations everywhere in the world, are mature people, people capable of identifying themselves with values far beyond local values, far beyond their own feelings of their own special importance and capable of extending their feeling of identification not only to their own family, their own social, racial, color or religious group, but to the whole human race.

None of us has been trained for this kind of work, none of us has been educated to be truly a world citizen. Each of us has been brought up in our own little place, concerned with the local values of our time and place. These values are entirely accidental. If we had been brought up in some other place, even across the street, our attitudes might have been quite different. We have been brought up to believe in certain things absolutely: the kind of things we should eat and should not eat, or at what time we can or should not eat them and how we should behave in all sorts of ways. We have been told how to dress,

how to do almost everything. Invariably we have been taught that these ways that are accidental for us, depending on where and when we happen to be born, are universally recognized as the only true and good ways and that they are superior to all other ways of acting, thinking and living. And, of course, it isn't true. It is not more virtuous to be able to eat beef than pork, nor indeed to be able to eat oysters than sheep's eyes, etc.

We have found so many ways of feeling superior because we have been convinced that above everything we must be good in the terms that happen to be acceptable to our own family at this particular time and place. And consequently we have learned to think that other kinds of people are inferior. We miss the fact that our ways, by definition, are also inferior from the point of view of others, and it is this fact which leads to so much misunderstanding.

Time was when naive people, working for the welfare of others, believed that it was possible simply to take techniques from one place in the world and lay them down somewhere else, with real hope that these techniques would then take root and grow and flourish. And, of course, this again isn't true. Techniques are not accepted by anybody because they are good for the people concerned. If they are accepted it is because the very people who are bringing these techniques are accepted: that is to say, liked and trusted.

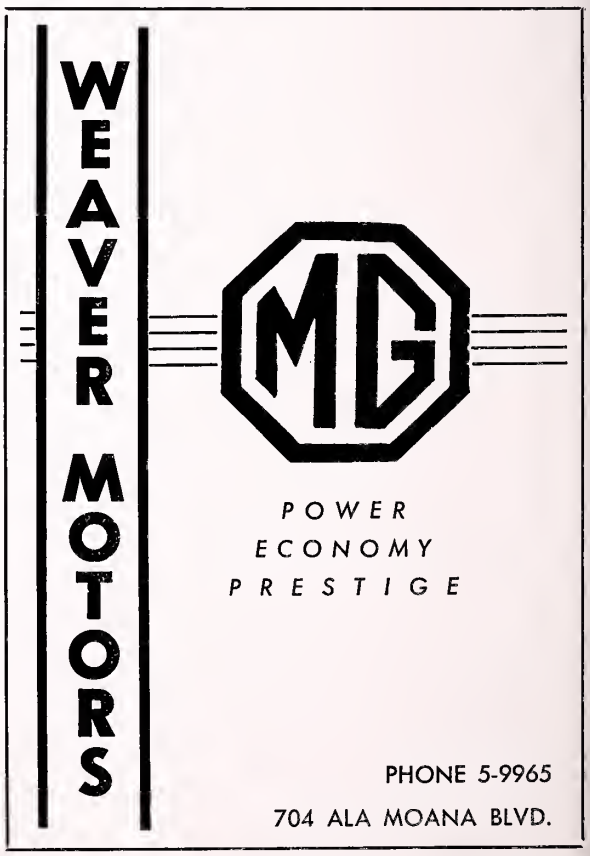
It is open to anybody to be accepted and to be trusted. It only requires taking thought about the feelings and emotional necessities of other people. It only requires to be able to feel things from their point of view, so that their feelings are never hurt, so that they can always feel safe in your presence. And when they can be assured of that, they will trust you, and from then on—but not until then—will the techniques you bring, or the ideals that you want them to attain, be accepted.

The whole of the work of WHO is an attempt to spread ideas and attitudes and knowledge. It is an attempt to help people to some extent to change their ways: to do things better and in a more efficient way. There is no hope that WHO can obtain any results in any country unless there is in WHO a whole chain of people who have a high degree of empathy—that is to say, who are able to feel from the point of view of other people, who can adopt an attitude of tolerance and behave in an utterly unselfish and devoted way. And such people are needed in the regions and Headquarters and in all fields.

There is no way of saying that such qualities of maturity are necessary only for a specific number of jobs, because immaturity is a virulent infection. It means a source of irritation and annoyance to a wide group of individuals. It is easy to say that people should be above that sort of thing and should not allow themselves to be annoyed by the peculiarities of other people, but that time certainly is not yet, and people do become annoyed by all types of irresponsibilities, by petty concerns for prestige, by little searchings for power, by all sorts of things that can get in the way of everybody's work.

We all have our limitations, but at least we can give what we have to give and we can give it wholeheartedly and without making things difficult for the others. Our own little drives for prestige must be kept under control. We must not take out our individual frustrations and disappointments on our colleagues, especially on those who are working under us, and who are looking to us for direction and guidance.

WHO cannot afford such attitudes. It is dependent on the continuous good will, devotion and self-sacrifice of every individual. I say to you in all seriousness that one person in this Organization who is pathologically immature, and one does not have to be very immature to be that, can make trouble that spreads very widely indeed and can jeopardize the work of some team working in some far-off place in the world.



CHECK LIST FOR YOUR PUBLIC RELATIONS*

Criticisms of nursing care which we hear today indicate that we need to give thought to our public relations at the critical place where the individual nurse has relations with the public—on the job.

People form their opinions of nursing on the basis of their own experiences. They evaluate what we're doing in terms of what they see and hear, and know personally. The standard against which we are measured is the patient's expectations of nursing service when he is ill.

The symbol of the professional nurse is her uniform, but inside that uniform the patient expects to find a human and understanding person who will be a tower of strength in time of crisis. As someone has said, the only minor operation is the one which happens to somebody else.

The professional nurse is inevitably being given more and more responsibility in the total picture of patient care. As this trend continues, and as we are given more and more assistance so we can concentrate on *nursing*, thought for our public relations is vital.

To help test your public relations, a brief check list has been prepared, Give yourself a score of 10 for each of the questions below to which your answer is an unqualified "yes."

DO I . . .

1. Encourage each patient to ask questions and let him see I consider them important?
2. Make rounds and speak a personal word to all patients for whom I am responsible?
3. Explain carefully what the patient's schedule will be and who will help him see that it is met?
4. Make myself available for conferences on the patient's progress and desires with his "next of kin"?
5. Remember personal tastes or requests which apparently mean something to the patient, whether or not they are essential to physical care?
6. Know the doctor's plan for care and rehabilitation and keep up to date on the patient's record, so that an understanding of his particular case is my guide?
7. Know the doctor's plan for care and rehabilitation and keep up to date on the patient's record, so that an understanding of his particular case is my guide in *working with him?*
8. Show that I am working closely with the patient's doctor by conferring with him and being present when he makes rounds?
9. Give patients confidence in the entire medical staff, as well as the patient's particular doctor?
10. Show consideration in my manner at all times, treating each patient, each visitor, and each coworker with the same respect I would show someone in my private life whom I wished to impress favorably and help when I am needed?

What's Your Score?

If you have a total score of 100, you may be sure your public relations are in good working order! In fact, anything less than 100 indicates that you may be reacting to work pressures by appearing—to your patients, to their families—hurried, brusque, or thoughtless.

The patient who only sees a professional nurse when it comes time for medications or treatments has no way of knowing he is our first concern.

* Reprint from *ANA in Review,* Volume II, Number 3, Autumn 1954.

MAKING YOUR DISTRICT TICK*

What makes your DNA tick?

Basically, it is the direction and satisfaction nurses get from face-to-face associations with each other—united by common concerns, stimulated by events which wouldn't happen on the beaten path.

The metropolitan district often has too large a population of nurses to tick as it should. The rural district finds members separated by too-great distances. The times set for meetings may not be convenient for everyone. And carrying out a program vital to each nurse in the district requires a training-ground for leadership and group-work skills.

Viewing the association from a national and state level, DNA problems of ticking almost form a pattern. Most SNA's are concerned today to find ways in which they can get more state-wide, active participation of their memberships.

Some are planning to redistrict. Others are exploring the possibilities of dividing districts into branches for the "grass roots" activities which need to be developed.

Find the Mainspring

In theory, the mainspring of your district is the group whose members enjoy face-to-face contacts. In practice, you have to develop such a group out of the potentials of your town or neighborhood, with a knowing eye on the conditions which are unique in your community.

If you have ideas, by all means let them be known! Do some barnstorming to collect other nurses' thoughts on the subject!

Your DNA board of directors is vitally interested in what you and all members think should be done to make your district tick to perfection. Give them the benefit of your thought and action. Then add your patient cooperation—remembering that it takes time and much individual adjustment to accomplish group objectives.

REGISTERED NURSE STUDENT PROGRAM

The Opportunity

An unusually attractive educational opportunity is presently available to Registered Nurses currently enrolled or accepted in colleges or universities in a course leading to a bachelor's or a master's degree in one of the various fields of nursing.

The Background

A goodly percentage of today's young nurses, reflecting the urge for self-improvement that characterizes their profession, are not content to rest on their laurels once they have gained State registration, but seek greater knowledge.

The Surgeon General is fully aware of the initiative demonstrated by these students in their commendable efforts to continue their education and enhance their professional stature in this fruitful field. Therefore, the Registered Nurse Student Program has been devised for the purpose of enabling certain selected individuals in this category to be appointed as commissioned officers and continue their education for a period not to exceed a calendar year, while they receive the full pay and allowances of a second lieutenant on active duty with the Army Nurse Corps. In effect, they will be able to

* Reprint from *ANA in Review,* Volume II, Number 3, Autumn 1954.

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complete this phase of their education under the sponsorship of the Army Medical Service.

Prerequisites for Selection (General)

To be eligible for participation in the Army's Registered Nurse Student Program, an applicant must—

Be twenty-one (21) years of age, but not have attained her thirty-second (32nd) birthday on the date of entrance into the Program.

Be a graduate of a school of nursing acceptable to the Department of the Army; be accepted for or matriculated as a full-time student in a college or university (approved by the National Nursing Accrediting Service and/or the Department of the Army) which offers a course in nursing leading to the bachelor's or master's degree; and be able to complete all requirements for this degree within 1 year.

Be a citizen of the United States.

Be unmarried.

Possess high moral character and personal qualifications.

Obligation

Participants must agree to serve on active duty for a period of 3 years which will include the time spent in training.

For further information write to:

The Surgeon General
Department of the Army
Washington 25, D. C.
Attention Chief of Personnel Division

WHAT ARE WE DOING ABOUT THE PRACTICAL NURSE?*

The last five years have seen an increase of 46 percent in non-professional workers in general hospitals, while the number of professional nurses increased by only 12 percent. By 1952, there were 70,000 fewer professional nurses than non-professionals working in hospitals registered with the AMA.

Sociologists tell us this is a trend which will continue. The non-professional member of the nursing care team is here to stay. The professional nurse is being up-graded. More and more responsibility is being given to her. As the profession moves upward, a vacuum is left below—a vacuum which must and will be filled.

The professional nurse who feels her position or status threatened by the practical nurse is justifiably concerned about what this trend means in terms of public opinion and public safety.

Not primarily as a means of protecting members of the nursing profession, but to protect the public from the dangers of malpractice, licensure for professional nursing needs to become mandatory in all states. This we must work for through our SNA's. Licensure is a responsibility of state governments under the Constitution. Today only 15 states have mandatory licensure for professional nursing.

It is just as important that the practical nurse be given status and the regulation of practice which licensure provides. Permissive licensure would prevent the use of the title "practical nurse" or "licensed practical nurse" by anyone who does not have the necessary training. Mandatory licensure would prevent the use of practical nurses in positions for which they are not licensed.

* Reprint from *ANA in Review*, Volume II, Number 3, Autumn 1954.

In only six states is a license now required for practical nursing; 42 states and four territories make some provision for licensing practical nurses, but six states and one territory have no legal regulation of practical nursing whatsoever.

The first point of emphasis must be to secure adequate preparation of the applicant for licensure.

In 1953 there were 8,543 students in state-approved and NAPNE[1]-approved courses for practical nurses. Compare this with a total of 102,019 students in basic programs in schools of professional nursing during the same year. The need for more emphasis on practical nurse training is obvious.

The urgent, dual task of the nursing profession is to take the fear of competition and transform it into constructive action and leadership along these lines: (1) increased enrollment in schools of practical nursing; (2) improvement of state licensure legislation.

FAREWELL TO A GREAT NURSING LEADER

Miss Annie M. Goodrich passed away on December 31, 1954. Affectionately known as Dean of American Nurses, Miss Goodrich was a vigorous, inspiring leader for all of us and her contributions to nursing have helped shape the progress of our profession.

Miss Goodrich helped found the Army School of Nursing in 1918 and received the Distinguished Service Medal for her accomplishments in World War I.

She served the American Nurses' Association as president from 1915 to 1918 and was active in helping to build the association as we know it today.

Miss Goodrich became the first woman Dean at Yale in 1923, heading the School of Nursing there, and officially retired in 1934 making her home in Colchester, Conn. She continued to be extremely active in the years following, in numerous official and advisory and consultant posts.

In 1939 Miss Goodrich was named one of the twelve outstanding women of the last fifty years at the New York World's Fair because of her contributions to the welfare of her community. It is not necessary to list further her many honors, accomplishments and awards, for they are well known to us.

A memorial service was conducted at Yale University, Dwight Chapel, on January 16, at 4:00 p.m., honoring Miss Goodrich. A tribute from the American Nurses' Association to her was presented at this service.

The Yale University Alumni Association has organized an Annie W. Goodrich Fund for the establishment of a professorship in her honor. Contributions and inquiries about the fund may be sent to Miss Elizabeth Bixler, Dean, Yale University School of Nursing, New Haven, Conn.

[1] National Association for Practical Nurse Education.

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Bumbalo, T. S., Gustina, F. J., and Oleksiak, R. E.: J. Pediat. 44:386, 1954.

White, R. H. R., and Standen, O. D.: Brit. M. J. 2:755, 1953.

against ROUNDWORMS

"Ninety per cent of the children passed all of their ascarides . . ."

Brown, H. W.: J. Pediat. 45:419, 1954.

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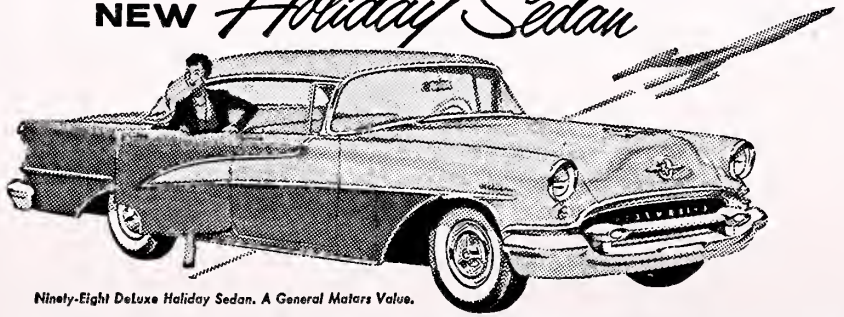
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LEAFLETS AVAILABLE:

Your Children's Feet and Footwear

Eleven points to watch in choosing children's shoes are given in an illustrated leaflet for parents released by the Children's Bureau, U. S. Department of Health, Education, and Welfare.

One of a series of leaflets dealing with physical problems of childhood, "Your Children's Feet and Footwear" stresses the importance of correct fitting of shoes to feet, rather than feet to shoes. A great deal of adult trouble with feet, the leaflet points out, starts in childhood and a big cause is shoes.

Illustrations show desirable types of shoes for children at different stages.

Parents are cautioned against indiscriminate use of x-ray machines as a means of determining a good fit in children's shoes. "Because it is so easy to misuse this machine," the leaflet says, "many doctors feel that no child should be exposed to this danger." The child who is having foot trouble should not be fitted with "orthopedic" or "corrective" shoes unless prescribed by a doctor. "Such shoes may have rigid arch supports or additions made to the heels. Rigid arches (and altered heels) in a child's shoes prevent the muscles from normal exercises when the foot is in use."

Copies of "Your Children's Feet and Footwear" may be purchased, for 10 cents each, from the Superintendent of Documents, Government Printing Office, Washington 25, D. C.

Other titles in this series of leaflets for parents, all purchasable from the Superintendent of Documents at 10 cents each are: "The Child With a Cleft Palate," "The Child With Cerebral Palsy," "The Child Who is Hard of Hearing," "The Preschool Child Who is Blind," and "The Child With Epilepsy."

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As nearly everyone knows, an executive has practically nothing to do except to decide what is to be done; to tell somebody to do it; to listen to reasons why it should not be done, why it should be done by someone else, or why it should be done in a different way; to follow up to see if the thing has been done; to discover that it has not; to inquire why; to listen to excuses from the person who should have done it; to follow up again to see if the thing has been done, only to discover that it has been done incorrectly; to point out how it should have been done; to conclude that as long as it has been done, it may as well be left where it is; to wonder if it is not time to get rid of a person who cannot do a thing right; to reflect that he probably has a wife and a large family and that certainly any successor would be just as bad, and maybe worse; to consider how much simpler and better the thing would have been done if one had done it oneself in the first place; to reflect sadly that one could have done it right in twenty minutes; and, as things turned out one has had to spend two days to find why it has taken three weeks for somebody else to do it wrong.—National Safety Council, *Safety News Letter,* June, 1954.

* Reprint from *Nursing Outlook,* October 1954.

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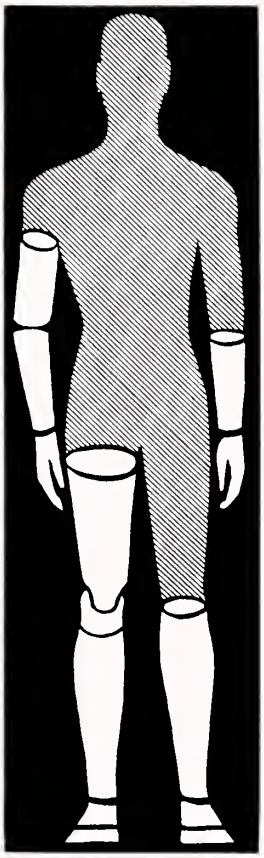
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more potent
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of sodium retention
and potassium depletion

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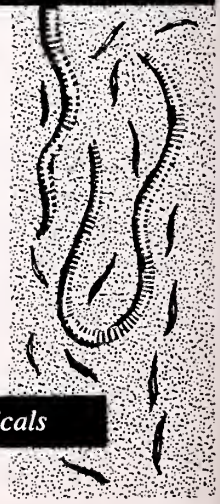
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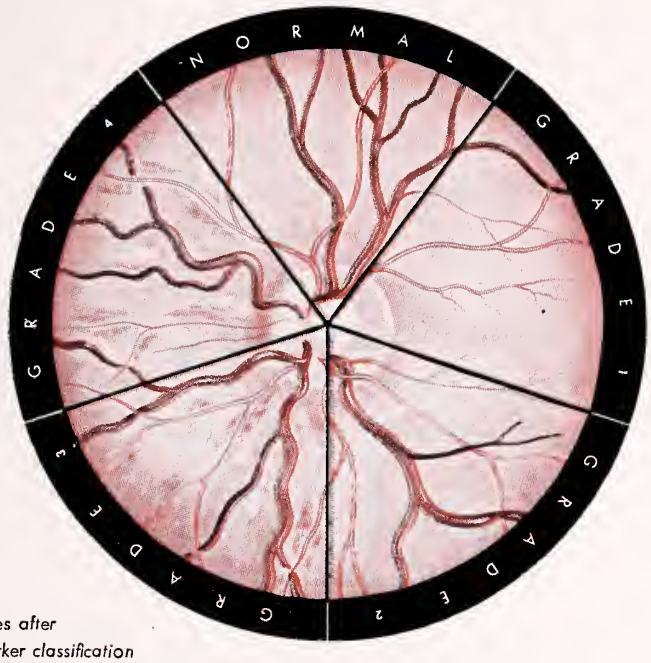
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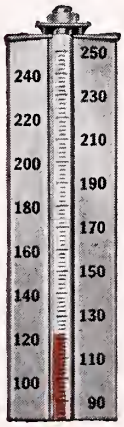
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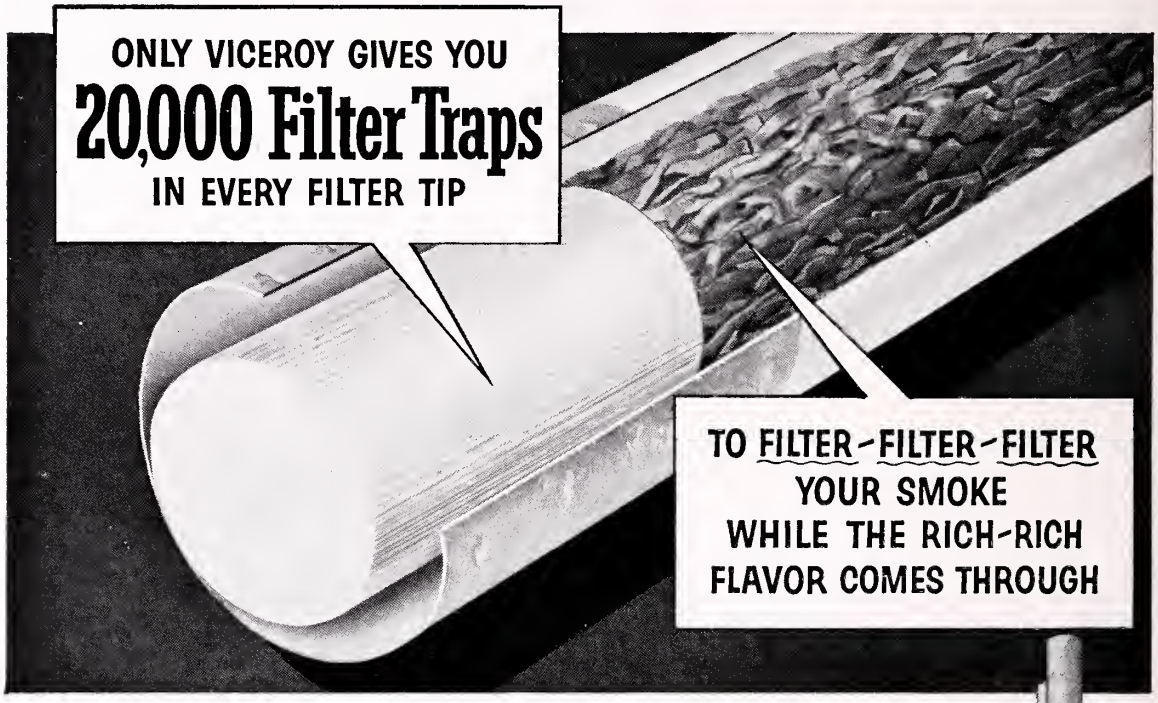


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BOOK REVIEWS

(Continued from Page 422)

Most of the subject matter has been reorganized and much of the previous text enlarged to keep abreast of new techniques and changing theories. The most significant additions are chapters on *Intestinal Polyposis, Megacolon, Techniques of Bowel Anastomosis* and a concise resume of *Fluid, Electrolyte and Nutritional Problems*. The chapter on ulcerative colitis is completely revised with emphasis on early, primary colectomy. While the observations of Crile and Turnbull are quoted, no mention is made of their recent contribution of the mucosal-grafted ileostomy. For the most part, however, the revisions are up to date and very well supported by quotations and a profusion of excellent new illustrations.

A not uncommon fault observed in texts on abdominal surgery is the author's tendency to be overly partial to his own established views and techniques. The reviewer feels that such is largely not the case in Maingot's new edition. Many diverse methods and attitudes are presented, often of historic interest only, but the discussions tend to be impartial and the author's personal recommendations are supported, for the most part, by reference and quotations from the world's eminent surgeons.

Abdominal Operations is a highly readable source book and technical guide which deserves the acquaintance of every general surgeon.

EDW. W. BOONE, M.D.

ALSO RECEIVED

Current Therapy—1955.

Edited by Howard F. Conn, M.D., 692 pp., Price $11.00, W. B. Saunders Company, 1955.

A valuable and practical compendium of treatment of practically everything. A useful book for the general practitioner's desk.

Peripheral Vascular Diseases.

By Edgar V. Allen, M.D., Nelson W. Barker, M.D., and Edgar A. Hines, Jr., M.D., Second Edition, 825 pp., illustrated, Price $13.00, W. B. Saunders Company, 1955.

Second edition of an authoritative, profusely illustrated textbook on peripheral vascular diseases, from the Section of Medicine of the Mayo Clinic.

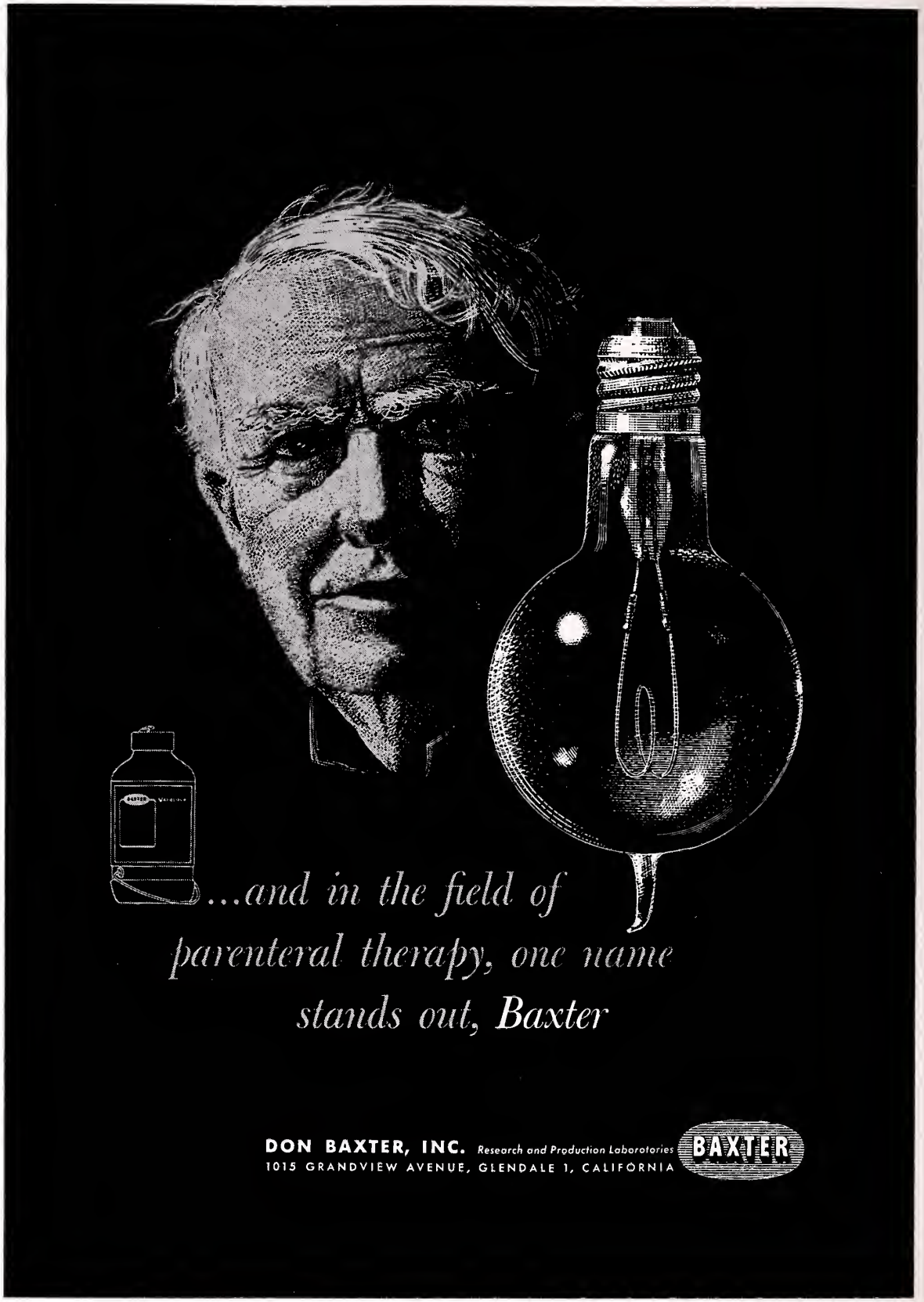
Modern Medical Monographs—Potassium Metabolism in Health and Disease.

By Howard L. Holley, M.D. and Warner W. Carlson, Ph.D., 131 pp., Price $4.50, Grune & Stratton, Inc., 1955.

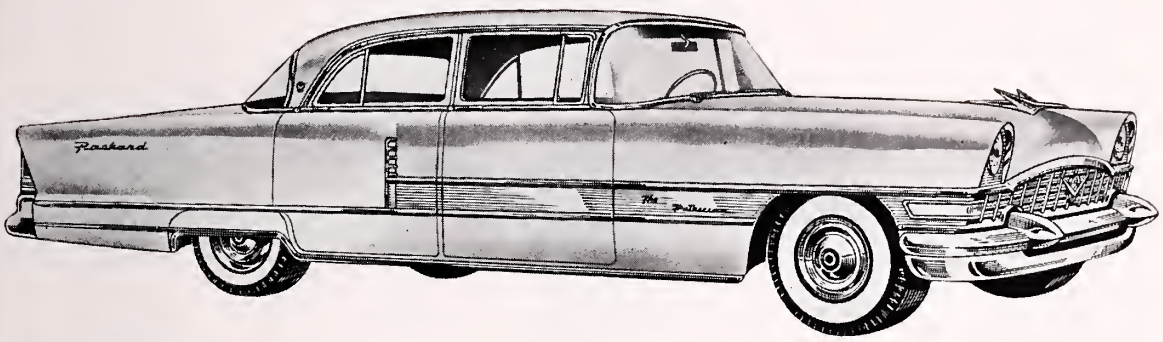
All about it. A useful reference.

(Continued on Page 451)

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in rheumatoid arthritis
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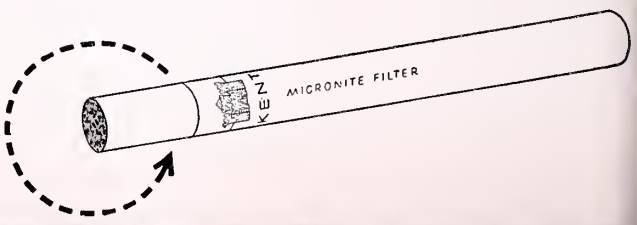
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BOOK REVIEWS

(Continued from Page 447)

Medical Clinics of North America.

January 1955—Clinical Advances in Medicine, pp. 1-322, figs. 1-70, $18 per clinic year, cloth binding, $15 per clinic year, paper binding, W. B. Saunders Company.

Symposium from Chicago on Clinical Advances in Medicine.

Regional Allergy of the United States, Canada, Mexico and Cuba.

Edited by Max Samter, M.D., and Oren C. Durham, 395 pp., Price $8.50, Charles C. Thomas, 1955.

Regional allergy of the *continental* United States, Canada, Mexico and Cuba. Hawaii and other noncontiguous portions of the United States are not mentioned.

Drugs in Current Use—1955.

Edited by Walter Modell, M.D., 147 pp., Price $2.00, Springer Publishing Company, 1955.

147 Readers-Digest-size pages of an alphabetical index to most currently used drugs, edited by the Associate Professor of Clinical Pharmacology at Cornell University.

Introduction to Thermodynamics of Irreversible Process.

By I. Prigogine, D.Sc., 115 pp., Price $4.75, Charles C. Thomas, 1955.

For advanced students of classical thermodynamics who are familiar with calculus.

Pediatric Clinics of North America.

February 1955, Symposia on: Unusual Infections of Childhood; Laboratory Tests and Special Procedures, pp. 1-332, figs. 1-55, $15 per clinic year (quarterly), W. B. Saunders Company, 1955.

Useful and interesting volume. The lead article by Dr. K. F. Meyer on Pasteurella Infections is alone worth the price of admission. Although this is a periodical there is no volume number.

The Surgical Clinics of North America.

February 1955, Chicago Number—Techniques and Procedures in Surgery, pp. 1-315, figs. 1-90, $18 per clinic year, cloth binding, $15 per clinic year, paper binding, W. B. Saunders Company, 1955.

Chicago's surgical practices are presented in 29 articles.

Atlas of Distribution of Diseases.

Leishmaniases, Price $1.25 folded, $1.50 flat, American Geographical Society, 1954.

A useful reference on Leishmaniases.

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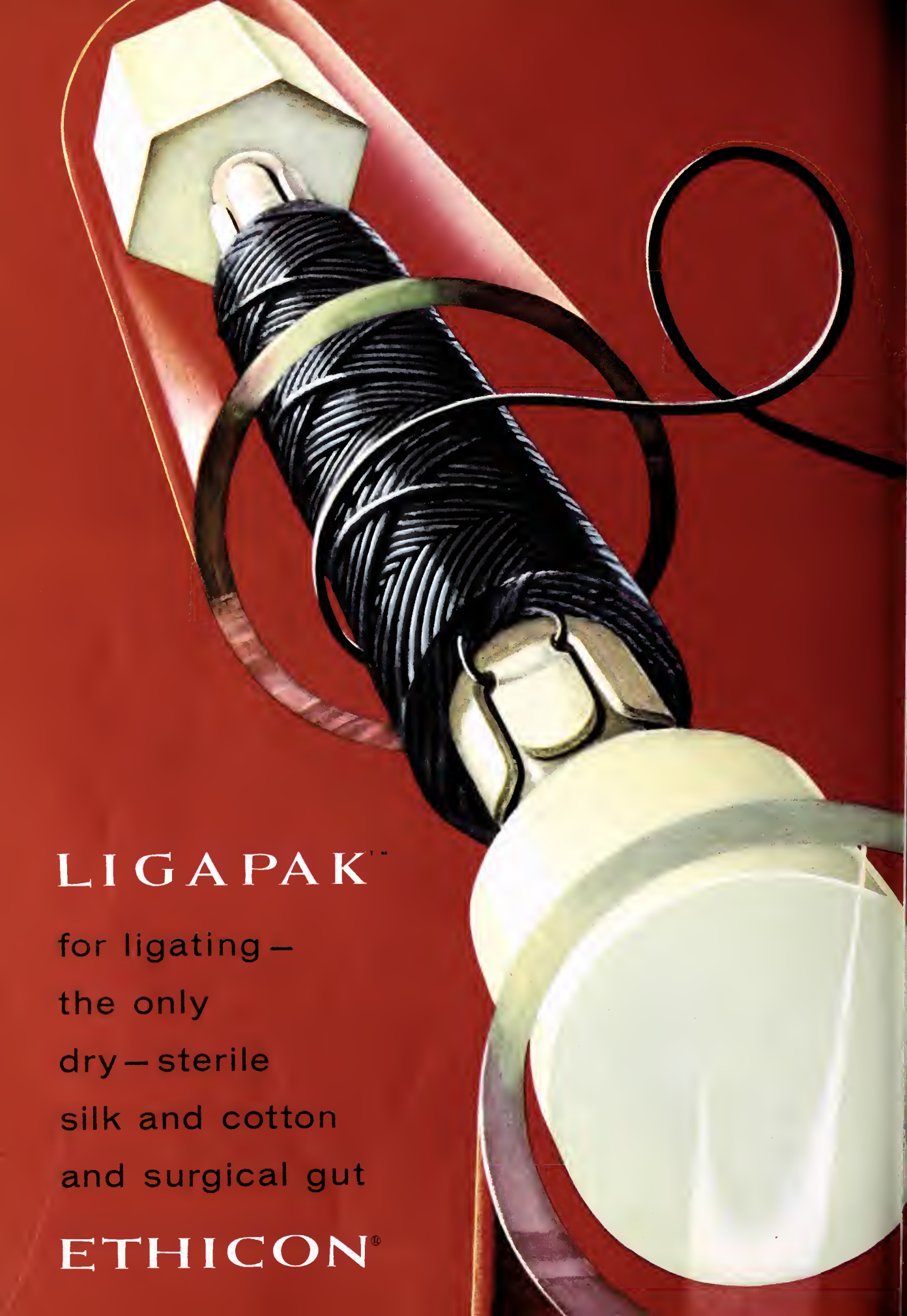
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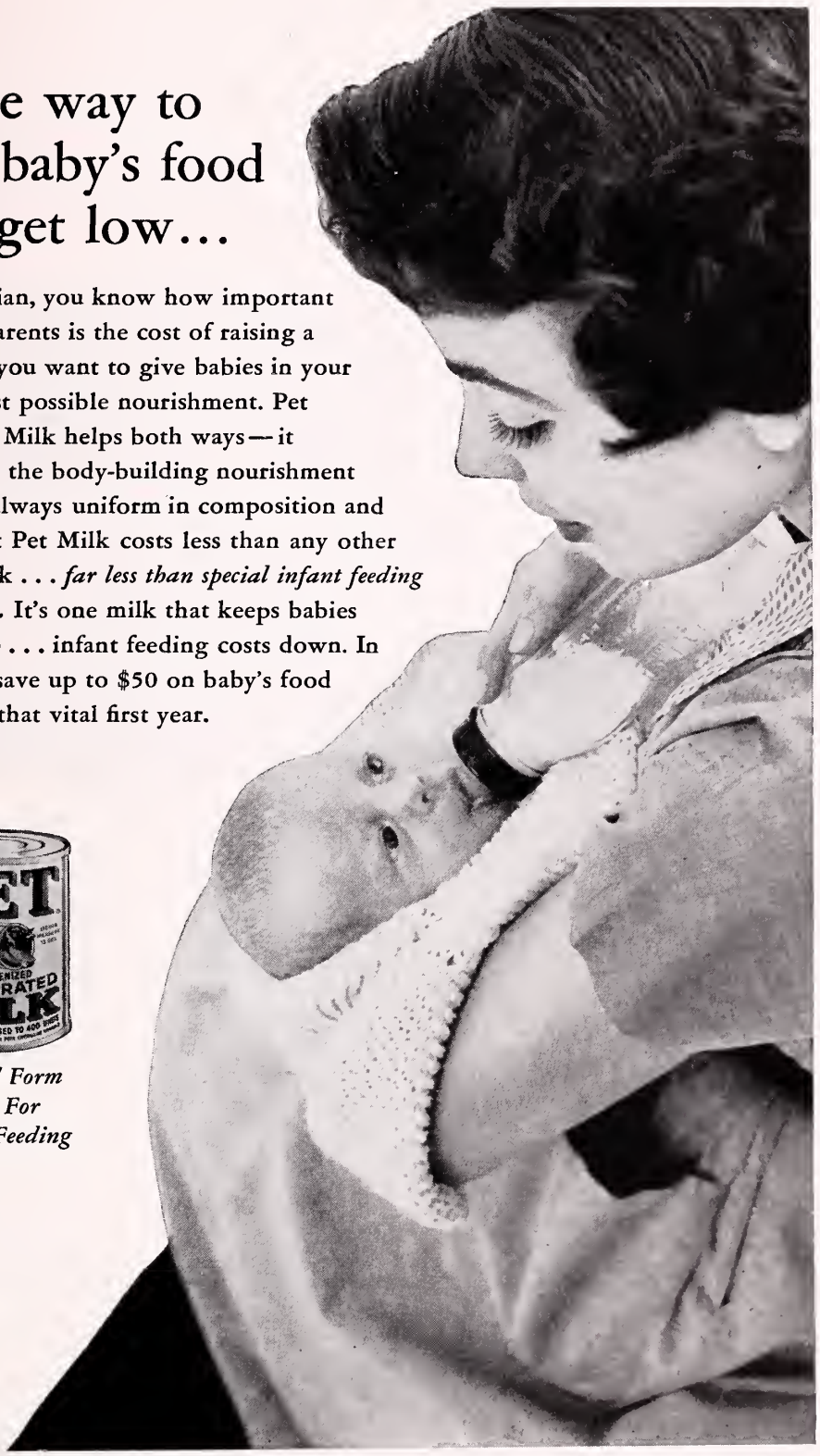

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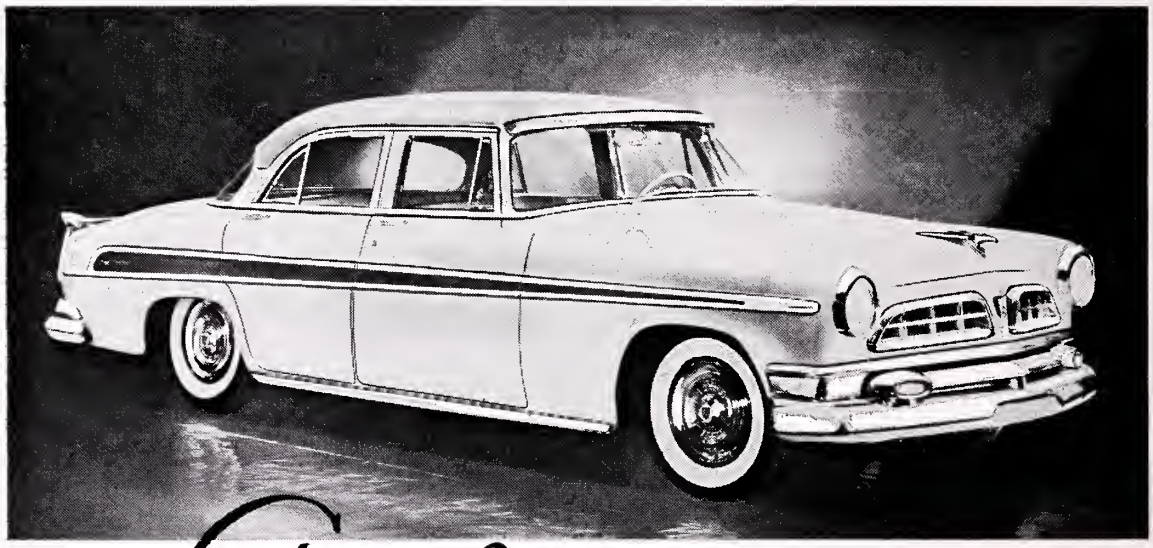


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COUNTY SOCIETY REPORTS

(Continued from Page 426)

Discussion of the Act presently before the Legislature to make Central Maui Memorial Hospital a community hospital was begun. Dr. Patterson felt that the representation on the proposed Board was unfair in that industry should have more members on the Board. Dr. St. Sure presented a lengthy discussion about this problem as it affects H. C. & S. Company's medical plan set up. Apparently the H. C. & S. Company would be interested in coming in to Central Maui Memorial Hospital if it could be definitely assured that the hospital would be completely divorced from politics. Since there is no definite assurance of this, their situation may be summed up as, "It is a county problem; not H. C. & S.'s problem." Dr. Underwood mentioned that there are no definite qualifications for staff membership proposed in the legislation. It was also brought out that the Act provides no means of financing the hospital. Dr. Fleming moved that we go on record as being in favor of a community hospital but not in favor of the Act as outlined. This was seconded by Dr. Underwood and passed unanimously. The secretary was instructed to communicate this action as well as the general criticisms of the act to those concerned.

Dr. Fleming moved that each member of the Maui County Medical Society, exclusive of the outer island and Hana members be assessed $25.00 annually in addition to their present dues. This was seconded by Dr. Sanders, a vote was taken and it was found that six were in favor and six were opposed. Dr. Kushi then cast the deciding vote in favor of the motion.

Dr. Ferkany suggested that a forum or panel discussion on some medical subject be conducted periodically during the year by local doctors for the general public. Dr. Fleming moved that this plan be approved. Dr. Ferkany seconded the motion and it passed unanimously.

L. S. ROCKETT, M.D.
Secretary

Kauai

The March meeting of the Kauai County Medical Society was held at the Wilcox Memorial Hospital on the evening of March 1, with Dr. Peter Kim presiding. Members present were: Doctors Boyden, Cockett, Fujii, Goodhue, Ishii, Kuhlman, Masunaga and Wallis.

The secretary was instructed to send a check of $120 to the Kauai Visitors Bureau as the Society's contribution to this organization. Members will be assessed later for the contribution.

President Kim reported that Dr. Wallis had been appointed delegate to the HMSA and Dr. Wade as alternate.

Application for membership of James A. Rutherford to Kauai County Medical Society was presented to the Board of Censors. Action deferred until next meeting.

Dr. E. Masunaga was re-appointed as chairman of the Program Committee.

The following officers were elected for the coming year: Webster Boyden, President; Keith Kuhlman, Vice President; Burt O. Wade, Secretary-Treasurer; Peter Kim, Censor—3 years.

W. BOYDEN, M.D.
Secretary

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Dec. 14, 1954

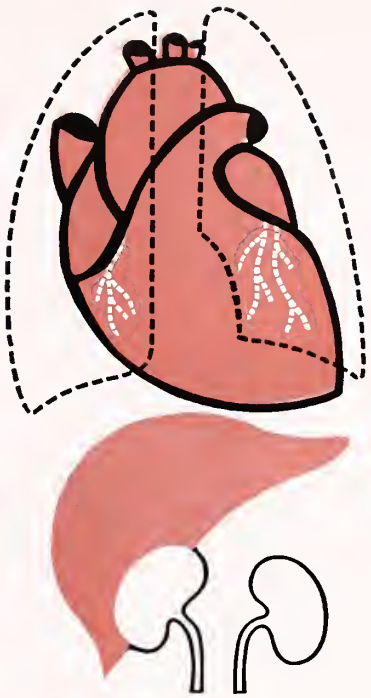
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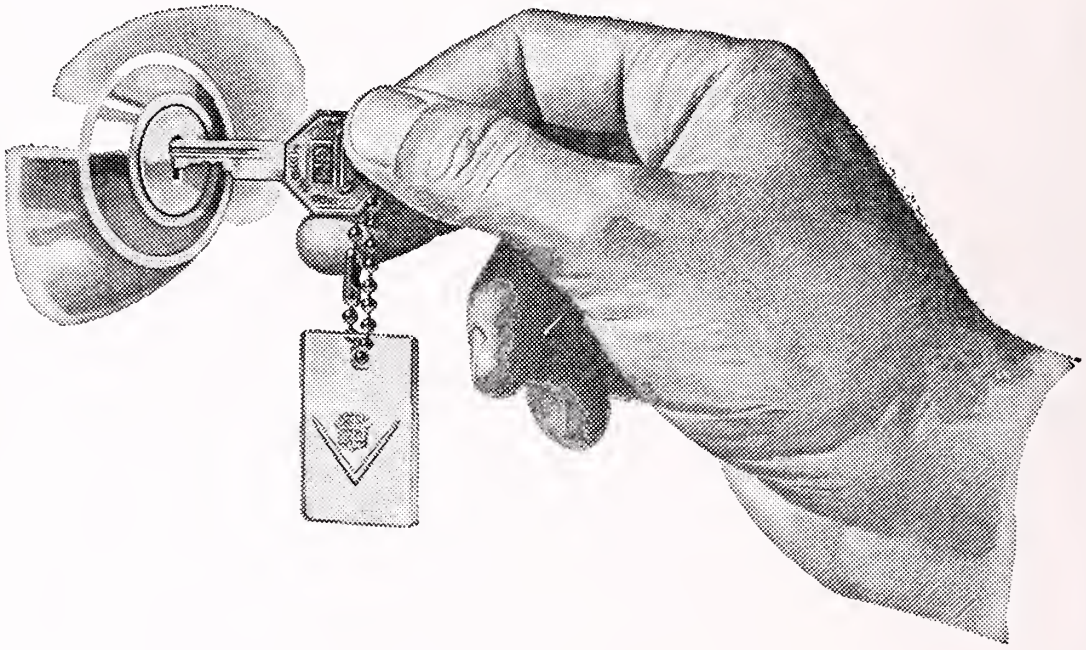
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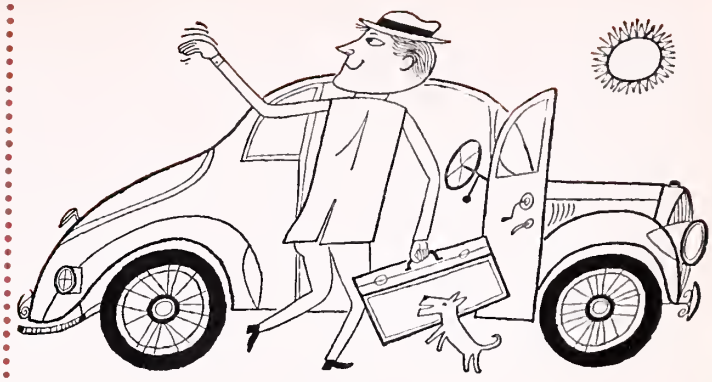
Yes, the evidence will be there—and the verdict without question: *Cadillac offers the greatest motor car performance of all time!*

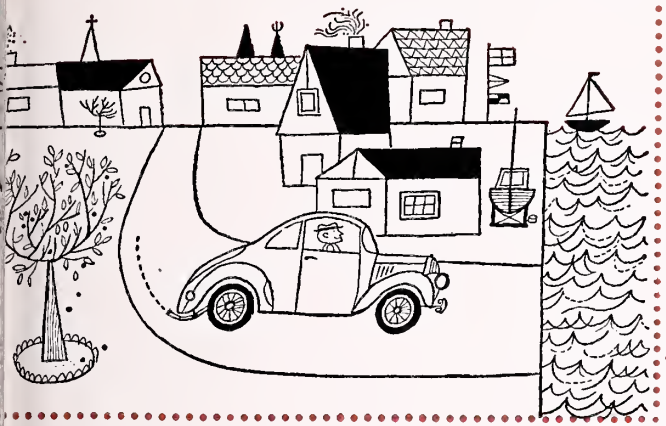
Stop in soon for a trial drive yourself. We'll be happy to give you the keys—any time!

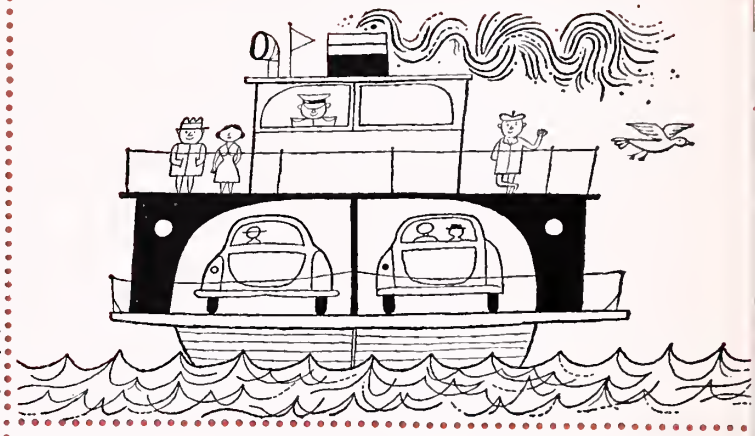
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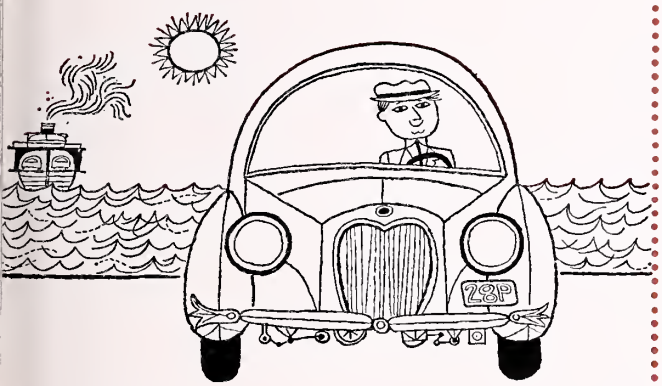
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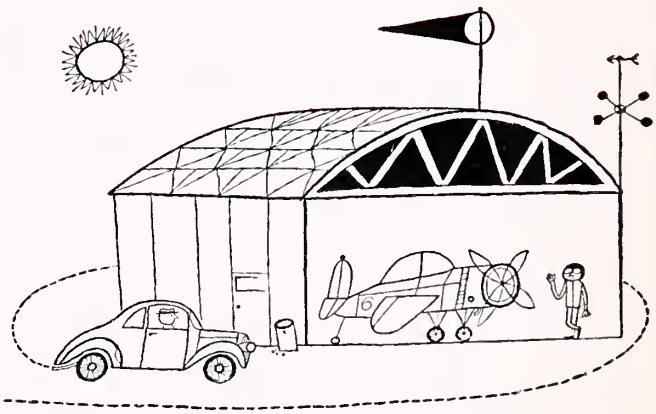






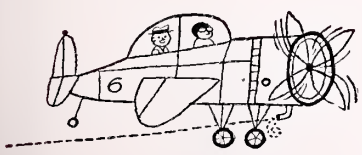






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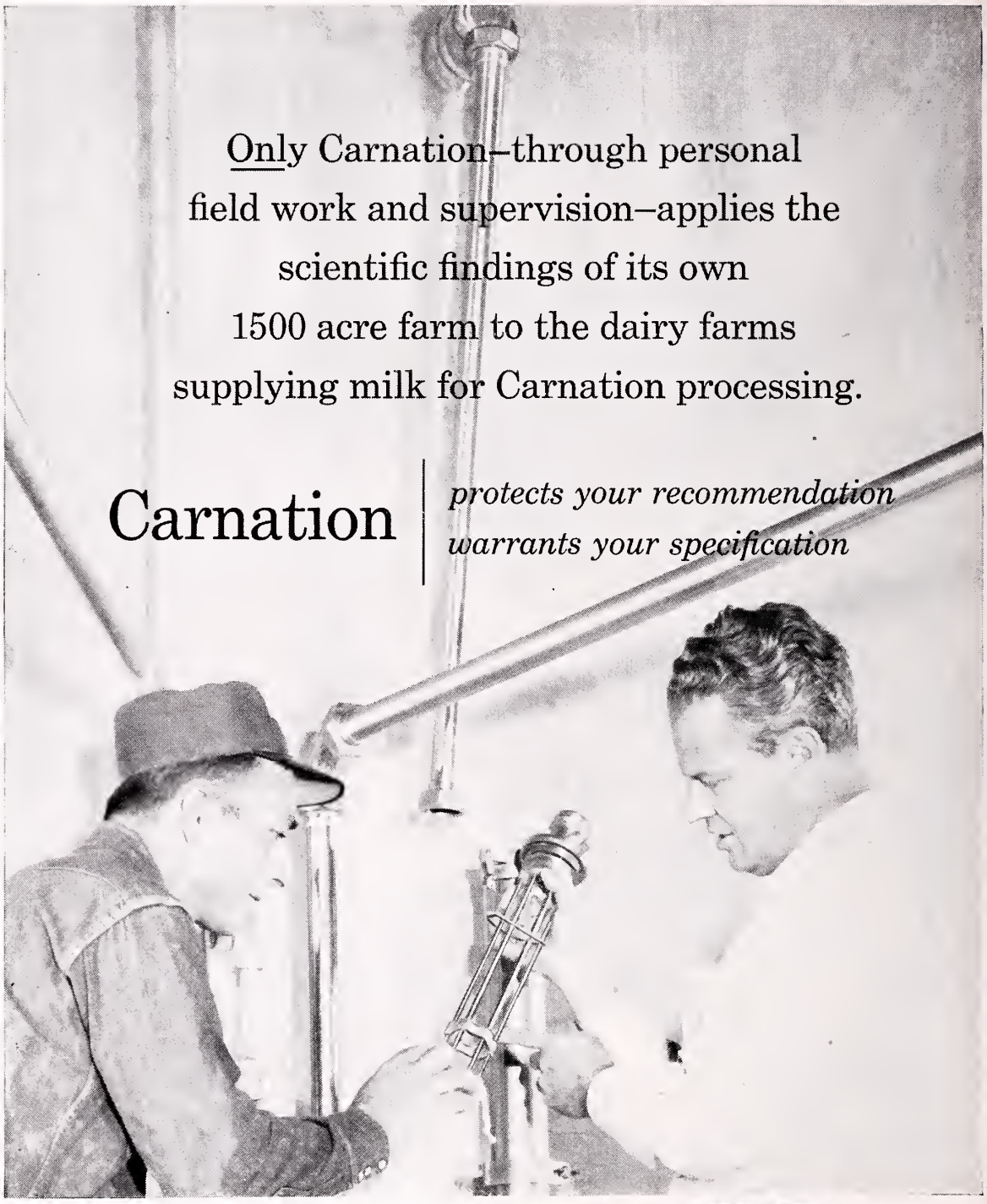
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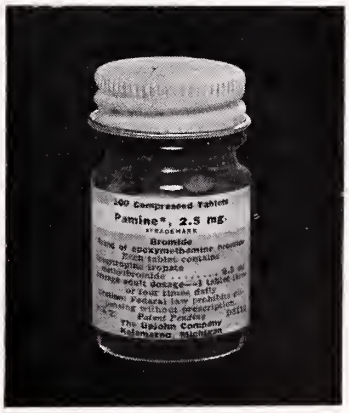
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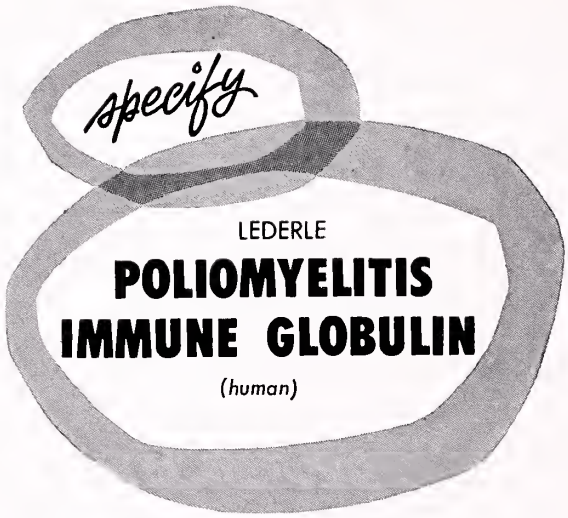
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One tablet one-half hour before meals, and 1 to 2 tablets at bedtime.

Supplied:
Bottles of 100 and 500 tablets.

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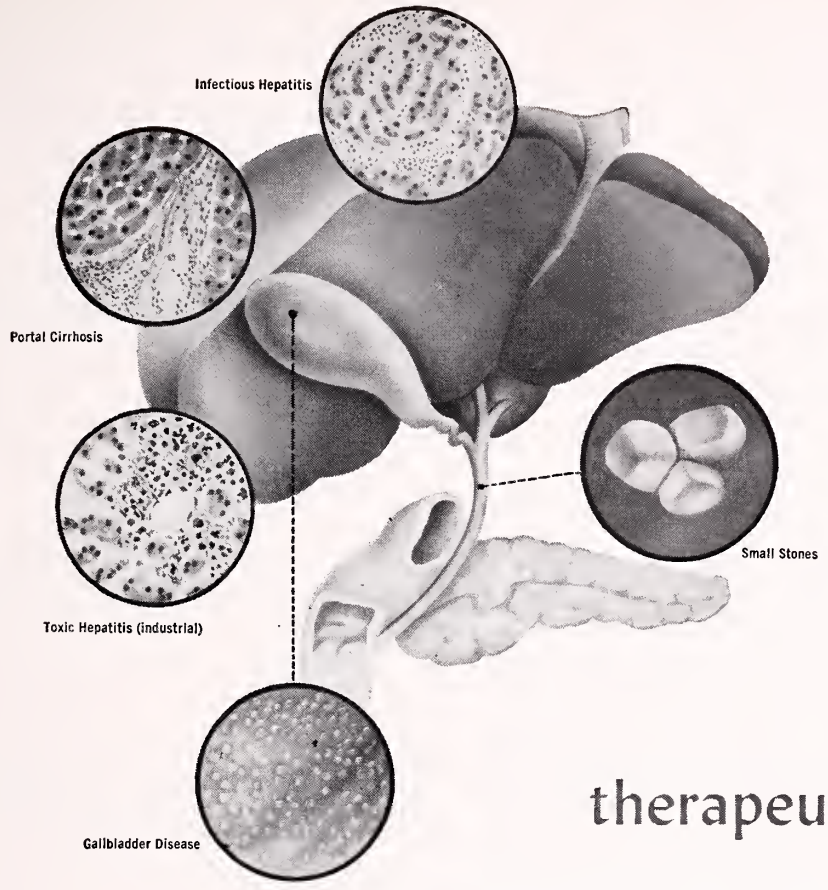
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*Schwimmer, D.; Boyd, L. J., and Rubin, S. H.: Bull. New York M. Coll. *16*:102, 1953.

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VOLUME 14 JULY-AUGUST, 1955 NUMBER 6



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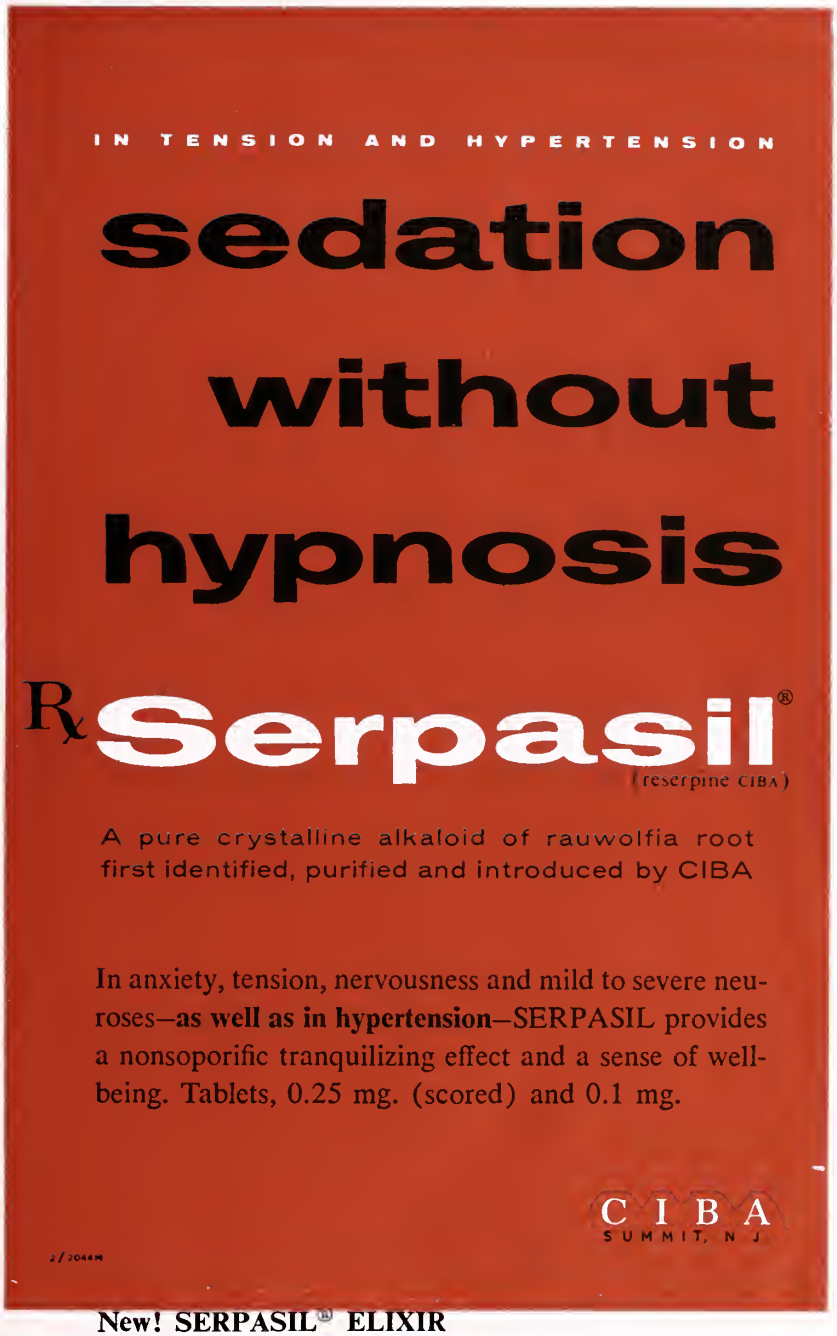
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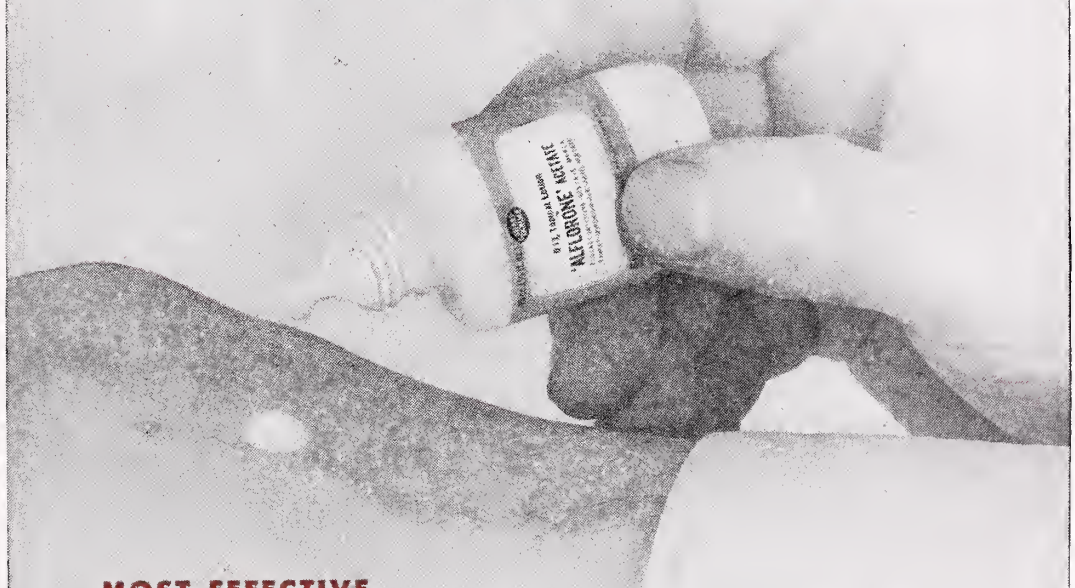
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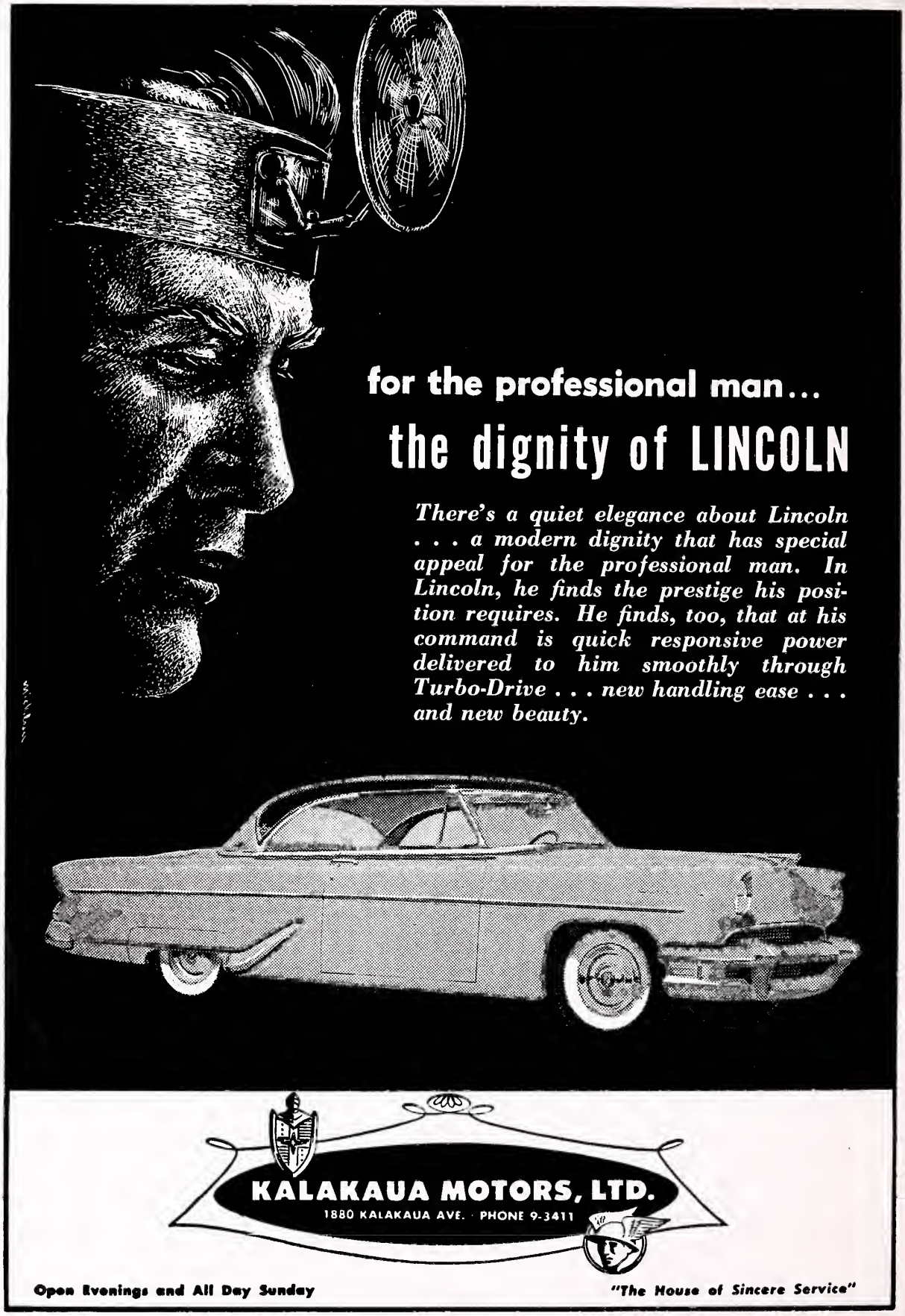
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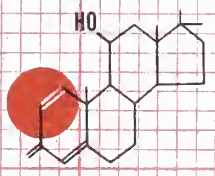
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1. Bunim, J. J.: Pechet, M. M., and Bollet, A. J.: J.A.M.A. *157*:311, 1955.
2. Waine, H.: Bull. Rheumat. Dis. *5*:81, 1955.
3. Tolksdorf, S., and Perlman, P.: Fed. Proc. *14*:377, 1955.
4. Herzog, H. L., and others: Science *121*:176, 1955.
5. Dordick, J. R., and Gluck, E. J.: J.A.M.A. *158*:166, 1955.

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(1) Payne, R. W.; Shetlor, M. R.; Forr, C. H.; Hellboum, A. A., and Ishmoel, W. K.: J. Lab. & Clin. Med. *45*:331, 1955. (2) Bunim, J. J.; Willioms, R. R., and Black, R. L.: J. Chron. Dis. *1*:168, 1955. (3) Holbrook, W. P.: M. Clin. North Americo *39*:405, 1955.

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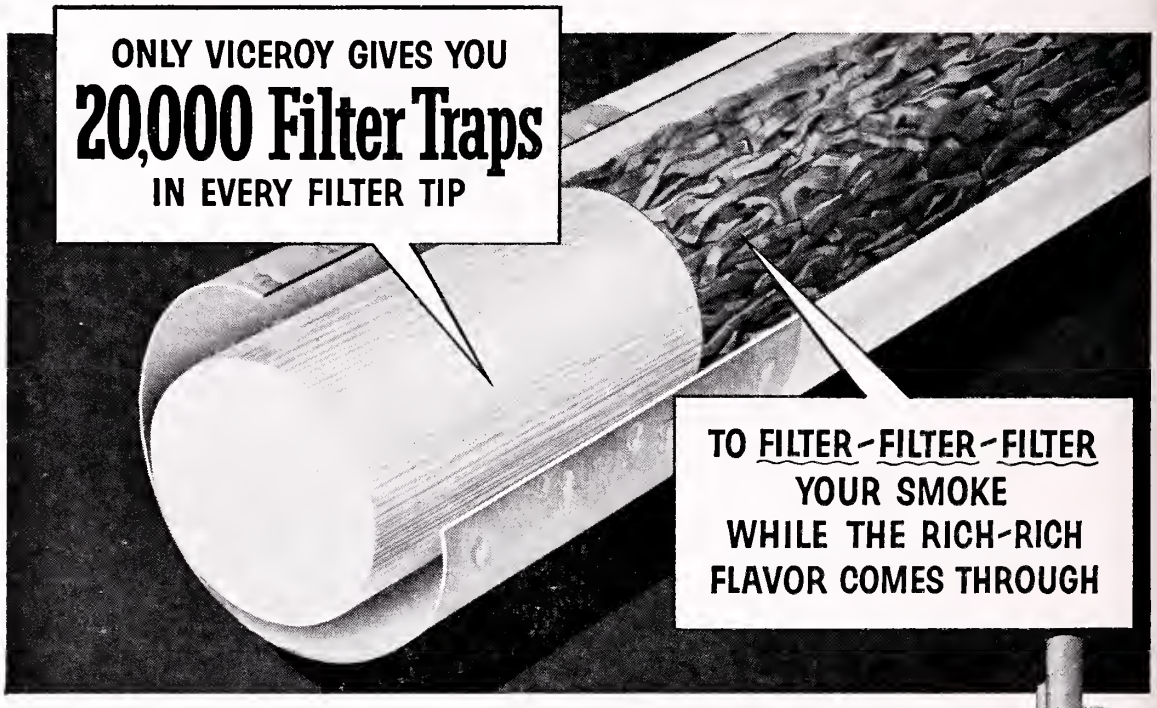
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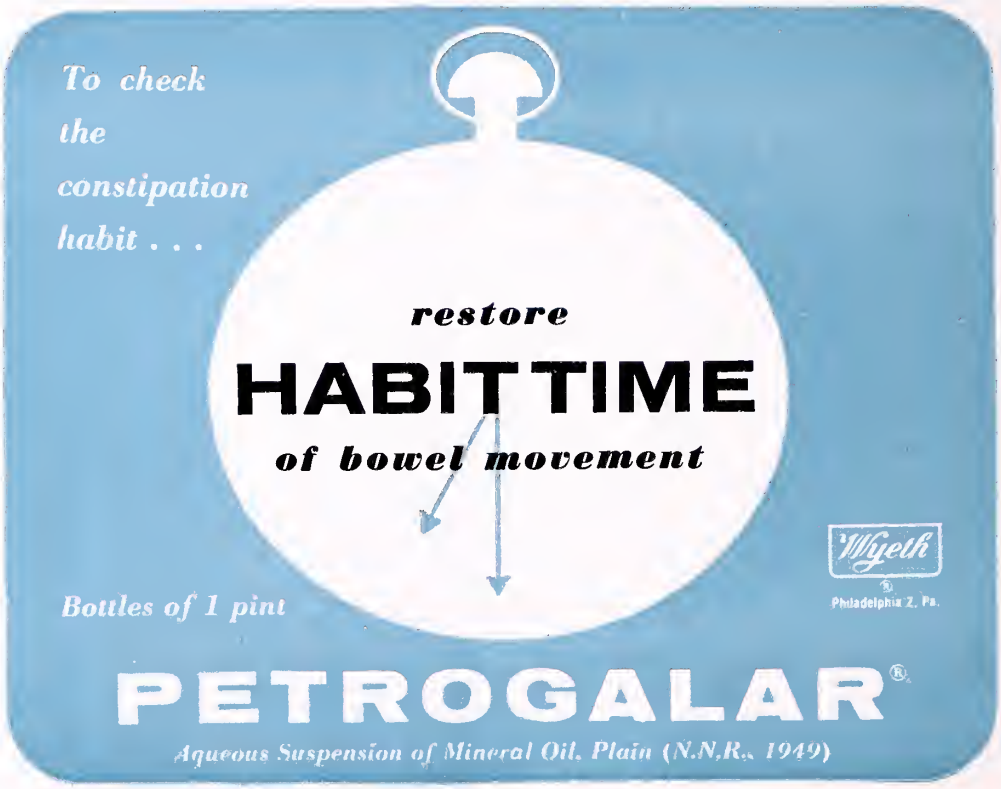
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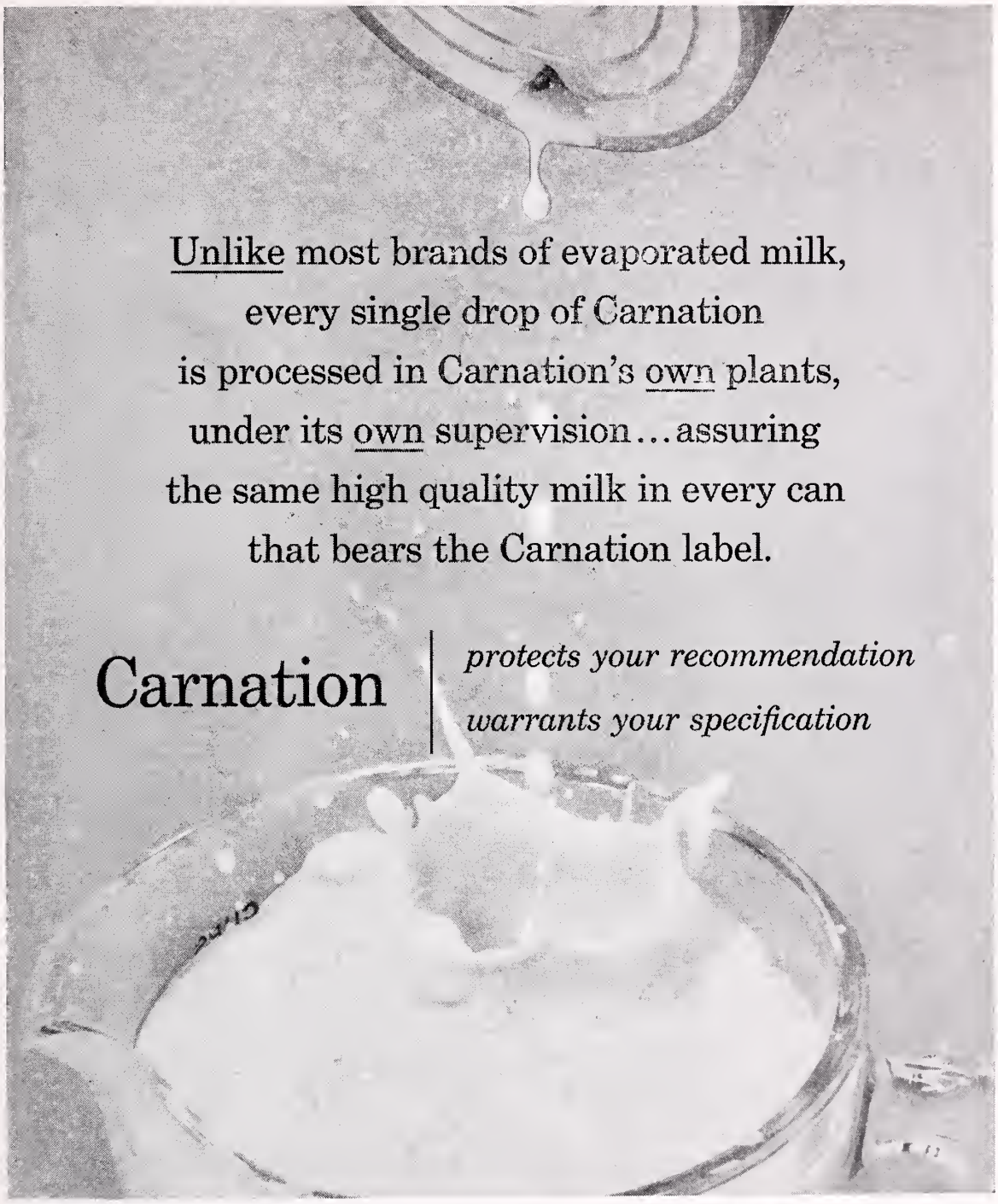
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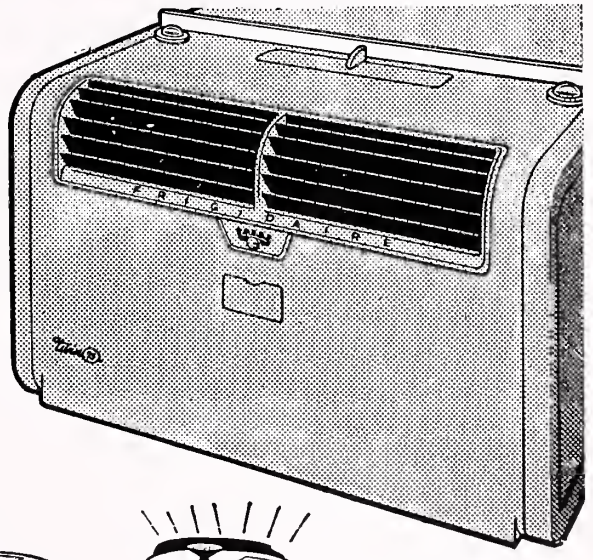
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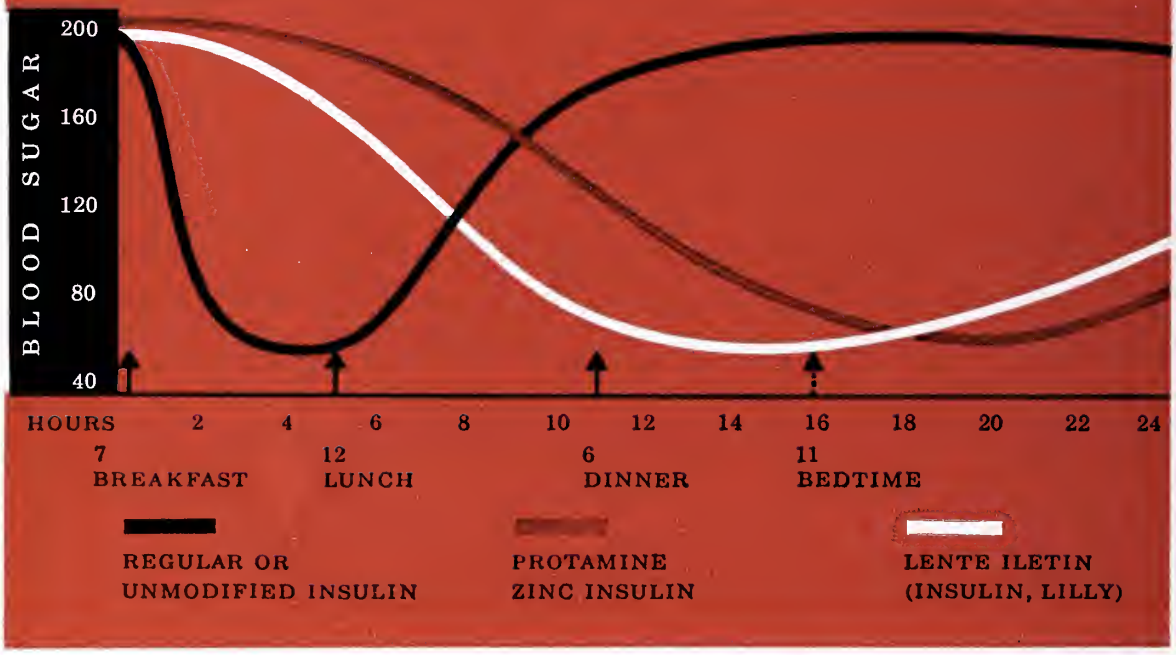
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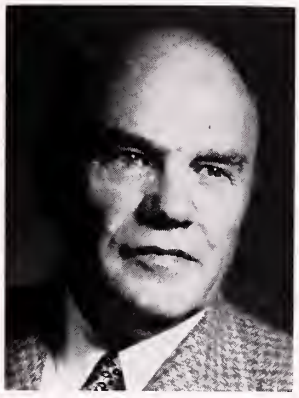
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THE ANIMAL FAT DIET AND ATHEROSCLEROSIS

NILS P. LARSEN, M.D., Honolulu, Hawaii

FOR DECADES, doctors as well as laymen have assumed that the wear and tear of years normally affected the arteries and slowly reduced their caliber. "Hardening of the arteries" was accepted as inevitable. There was nothing to be done about it. Some got it earlier than others, but it was accepted like taxes and death.



DR. LARSEN

Recently this attitude has completely changed in all scientific circles devoted to the study of arteriosclerosis, and particularly regarding the most common form of arterial hardening, known as atherosclerosis. Recent research suggests that this process is preventable and possibly reversible.

The process known as senescent arteriosclerosis is a form of arteriosclerosis due to a chemical change in the arterial wall having no relation to sex, diet or heredity. It occurs in vessels with or without atheromatous change. There is a deposit of calcium, lipids, proteids, etc., which increases with each decade. It is the aging artery. It does not necessarily produce any clinical symptoms.

Atherosclerosis on the other hand is due to a slow deposit of lipid material which produces yellow, rubberlike plaques in the intima of the arteries. These later may calcify in areas and may ulcerate. This process slowly reduces the caliber of this vital "pipe-line" and so decreases the blood supply to various organs and tissues. The resulting "disease" will depend on which organ is most affected. Certain stress points in the arterial tree tend to have the first and most severe deposits.

There are many other forms of arterial disease, i.e., Mönckeburg's calcification, arteriolar disease and others. All these may be present in the same individual, they often overlap, yet they are separate entities. They may be part of the aging circulation. This discussion will be limited to atherosclerosis.

Presidential address to the ninety-ninth annual meeting of the Hawaii Medical Association, May 6, 1955.

[1] Dock, W.: The Predilection of Atherosclerosis for the Coronary Arteries, J.A.M.A. 131:11 (July 13) 1946.

Different parts of the arterial tree can be affected to different degrees by atherosclerosis.[1] Aging is associated with an increasing amount of it, but it is not due to aging.

The first plaque is often found at birth in the region of the ductus arteriosus. Sjovall[2] reported "100% of humans six months or more old have arteriosclerosis."

There are many influencing factors. Known important factors are: (1) heredity, (2) sex and age, (3) diseases such as nephrosis, diabetes, etc., (4) hypertension, and lastly (5) diet. Evidence is increasing to indicate the importance of diet.

However, if these changes are to take place in the arteries, certain basic conditions are necessary.[3] (a) A certain level of arterial pressure must be present. There is no defect, for instance, in veins, until a pathological condition raises the pressure well above normal. (b) Some change must take place in the circulation of the arterial wall, so that at some point it is no longer able to handle blood with an overload of lipids. (c) There must be a rise in the cholesterol content and the phospholipid ratio. A rise in cholesterol alone seems well handled. (d) Certain inhibiting factors, estrogen, heparin, or some such, may influence the others.

Recently various chemical changes have been shown to be intimately associated with this process. The proportion of alpha-beta lipo-proteins, the hormones, the mast cells, the arterial wall anatomy and its circulation, local injury, and what role diet may play, have all been shown to be of possible etiologic importance. Throughout America evidence suggests that an increasing amount of atherosclerosis is affecting younger and younger people. The autopsy findings of 300 Americans[4] killed in Korea indicated that at least 40 per cent (average age, 23) had definite coronary sclerosis. The Swedish report of 140 killed soldiers, with an average age of 28, noted 50 per cent with atherosclerosis of the coronaries. At about the same time, E. L. Benjamin[5] reported that of 200 natives

[2] Sjovall, H. and Wihman, G.: Comparative Autopsy Study of Arteriosclerosis in Stockholm, Sweden (Urban) and Lund (Rural), Acta Path. et Microbiol. Scand., Supp. 20, 20:1 (Jan.) 1934.

[3] Barr, D. P.: Personal Communication.

[4] Enos, W. F., reported at American College of Physicians Meeting, April, 1954.

[5] Benjamin, E. L.: Report of 200 Necropsies on Natives of Okinawa, U. S. Naval Medical Bulletin, 46:495 (Apr.) 1946.

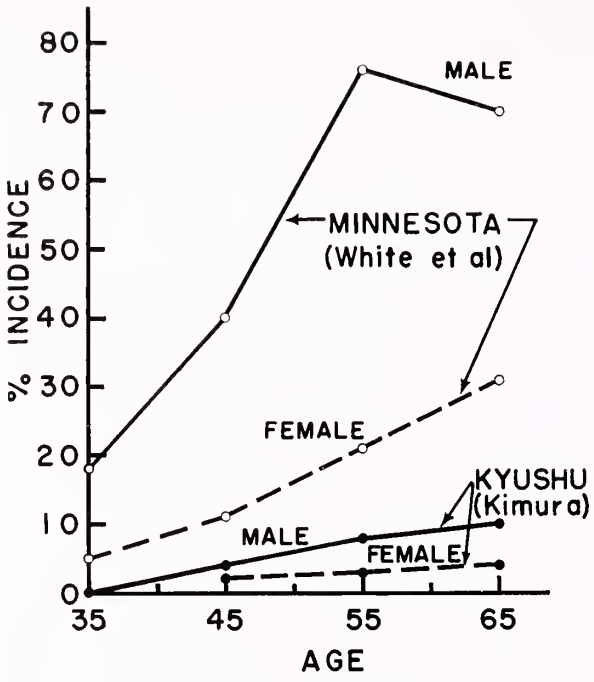


FIG. 1.—Evidence of high grade coronary sclerosis.

killed on Okinawa, only two showed any sclerosis. I shall present tables to try to indicate how rapidly this "aging circulation" is rising in the United States.

This problem of the factors involved with aging, however, is not a new one. Dr. Benjamin Rush in 1828[6] tried to analyze the cause of old age. He collected the case histories of a large number of people who had lived to 80 and beyond, to see if there were any common factors that would give more understanding of longevity. His observations covered a period of five years, mostly on people he knew. He received some reports from colleagues. There was, he said, a great sameness in the history of most of them. He goes on to comment, "I shall, therefore, only deliver the facts and principles which are the result of inquiries and observations I have made regarding this subject.

> I.—I shall mention the circumstances which favor the attainment of longevity.
>
> II.—I shall mention the phenomena of body and mind which attend it.
>
> III.—I shall enumerate its peculiar diseases, and the remedies which are most proper to remove or moderate them.

Dr. Rush then enumerated the following possible factors which favor longevity.

1. "Descent from long-lived ancestors. Everyone usually had such from both sides, but all at least from one side. The capacity of life they had derived from their ancestors."

2. "Temperance in eating and drinking" was usual; however, one man of the series was intemperate in his eating. Five of the series were intemperate in their drinking. These were all day laborers. They had deferred drinking until they "began to feel the languor of old age."

All, for at least forty to fifty years, used tea, coffee, bread, and butter twice a day. "The duration of life does not appear to depend so much upon the strength of the body or upon the quantity of its excitability as upon the exact accommodation of stimuli to each of them. A watch spring will last as long as an anchor, providing the forces which are capable of destroying both are in exact ratio to their strength."

3. "The moderate use of the understanding" seemed necessary. He commented that literary men are more long-lived than other men. "Business, politics, and religion, which are the objects of attention of all classes, impart a vigor to the understanding, which, by being conveyed to every part of the body, tends to produce health and long life."

4. "Equanimity of temper" was also mentioned as a common factor. "The violent and irregular

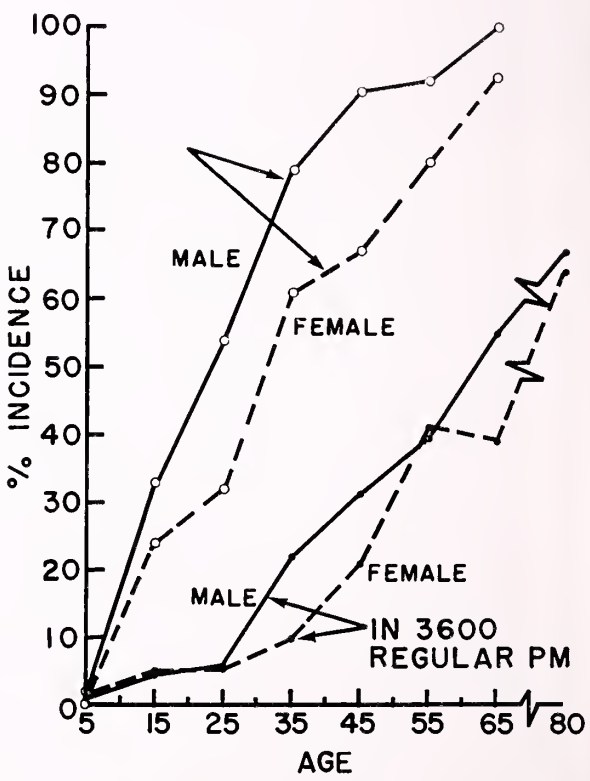


FIG. 2.—Evidence of coronary sclerosis (Kyushu, Japan) in a careful study of 1,007 autopsies.

[6] Rush, B., from The Art of Money Getting, by Leman Thomas Rede, London, Joseph Smith, 193 High Holborn, 1828.

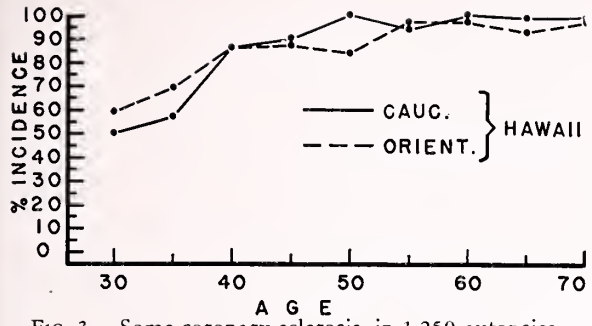


FIG. 3.—Some coronary sclerosis, in 1,250 autopsies.

actions of the passions tend to wear away the springs of life." He then commented on the fact that those on annuities lived longer than those who had to worry about each day's care. "The desire of life is a very powerful stimulus in prolonging it. Despair of recovery is the beginning of death in all diseases." Equanimity of temper was important, although there were some exceptions in favor of passionate men and women.

5. Matrimony was an experiment tried by all but one, who seemed to live on in spite of the lack of the solace of a wife. Several women bore ten to twenty children and suckled them. Dr. Rush reported one he met in her one-hundredth year, "who bore a child at sixty, menstruated until eighty, and frequently suckled two of her children, though born in succession, at the same time. She had passed the greatest part of her life over a washing tub."

A sedentary life did not prevent longevity unless associated with intemperate eating and drinking. In women, longevity had been observed many times without much exercise of body. "I have not found that acute, nor that all chronic diseases shorten life." However, he found only one who had had a disorder of the stomach, and in him it arose from an occasional rupture. The loss of teeth seemed to have no influence on longevity, and neither did baldness, nor gray hair in middle age. One eighty-year-old began having gray hair at 11. Even heredity was not absolute. There was not one who had not lost brothers or sisters in their early or middle life.

It does seem interesting that this report of 125 years ago approached quite well present-day concepts of what might affect the arterial tree and so influence the process of aging.

The following graphs tell us something about atherosclerosis in the aging circulation:

Figure 1 was received recently from Professor N. Kimura of the Kyushu University in Japan. It shows a curve of high-grade sclerosis found in Caucasians in Minnesota versus that found in Japanese in Kyushu. You will note that at age 65 only 10 per cent of the Japanese males were reported with severe coronary sclerosis, whereas 70 per cent of the males in Minnesota were reported with severe coronary sclerosis. Prof. Kimura and Dr. Ancel Keys[7] went over the graphs together in an attempt to make them comparable.

Figure 2 is a careful study by Professor N. Kimura in which he personally cut open the coronaries from one end to the other and looked for any evidence of disease. You will note that by age 65, 100 per cent of the Japanese males showed some sclerosis. On this same chart, you will note the graph based on routine findings by his pathology department. About 60 per cent (when not particularly looked for) are reported with evidence of coronary sclerosis at age 65. It is evident that if the aging circulation is to be compared, a clear-cut definition must be used so that the findings can truly be compared, and a complete examination of the whole length of the artery must be made.

Figure 3 is a report on 1,250 autopsies in Hawaii comparing the Caucasian with the Oriental.[8] A careful definition of each of five stages of blood vessel change was given. The coronary was opened from end to end and carefully studied. You will note here that there is some evidence of coronary sclerosis in over 90 per cent in both Orientals and Caucasians.

Figure 4 compares severe coronary sclerosis in these two groups. At age 65, severe coronary sclerosis is found in only 30 per cent of the Orientals but in 75 per cent of the Caucasians. It will also be noted that prior to the age of 45 the amount of severe coronary sclerosis is somewhat parallel, but beyond the age of 45, there is a very striking difference in severe atherosclerosis, although not as great a difference as that previously mentioned.

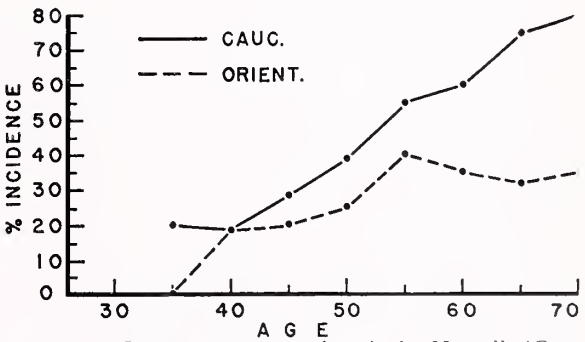


FIG. 4.—Severe coronary sclerosis in Hawaii (Caucasian vs. Oriental).

[7] Keys, A., Personal Communication.

[8] Larsen, N. P.: Atherosclerosis—An Autopsy Study, HAWAII MED. J. 14:129 (Nov.-Dec.) 1954.

TABLE 1.—*Comparison 1933 Autopsies—Mayo Clinic Sclerosis Study with 1954 Autopsies —Hawaiian Sclerosis Study.*

	NO. AUTOPSIES		CORONARY SCLEROSIS			AORTIC SCLEROSIS		
	Age 30-50	*Age 50+*	*Age 30-50*	%	*Age 50+*	*Age 30-50*	%	*Age 50+*
Mayo males	959	1,769	20		51	21		63
Haw. males	142	662	56		83	59		83
Mayo females	586	817	9		35	15		55
Haw. females	101	345	40		82	51.5		84

Table 1 is a comparison of our studies with a similar study conducted at the Mayo Clinic and published in 1933.[9] The comparison, therefore, is of two groups of Americans who died over twenty years apart. Twenty years ago, they reported 20 per cent of males under 50 with definite to severe coronary disease. They found that frightening. Using the same criteria as well as words can convey them, we found 56 per cent of males under 50 with definite coronary damage. Over 50 years of age, the figures were: 1933, 51 per cent; 1954, 83 per cent. In women, the change was just as striking. In 1933, 9 per cent; in 1954, 40 per cent. Over age 50 in 1933, 35 per cent; in 1954, 82 per cent. Comparable figures are shown for the aorta; the aorta always showed a higher percentage with damage than did the coronaries.

Many studies indicate that a high animal fat diet may be a prime etiological factor in developing an increased amount of this arterial deposit and therefore, if the animal fat in the diet is raised, an increasing number of people will be expected to develop clinical symptoms due to more severe atherosclerosis. The process itself is possible in all humans.

Have thirty years of high-fat dieting in the U. S. A. caused this increased pathology of the arterial tree? Has the American nutritionists' teaching of one quart of milk a day, one pat of butter, and one egg finally caught up with us? This "disease" kills 60 per cent of those over 50, as compared to only 9 per cent dead of cancer.

A well-controlled and clear-cut experiment was reported recently by Dr. E. H. Ahrens *et al.*,[10] from the Rockefeller Institute for Medical Research, on certain diet factors that produce the atherogenic blood picture. The group took six obese people, kept them on a constant diet as to protein, carbohydrate, fat, and vitamins but replaced the animal fat with vegetable fat. In each case and every time, the cholesterol and the cholesterol-phospholipid ratio dropped significantly. When the animal fat was again eaten the blood picture reversed.

Every disease in which both the cholesterol and the cholesterol-phospholipid ratios are high in the blood is associated with heavy atherosclerosis.[4] The familial types of xanthomatosis even show coronary plaques in infancy. Whether a lowering of cholesterol in the blood by 100 mg per cc will change the atheromatous deposits remains to be proven. Kinsell and his associates[11] reported that such a lowering was accomplished by replacing the animal fat in the diet by vegetable fat, or dairy products (milk, eggs and butter) diet by vegetable fat.

When the cholesterol and cholesterol-phospholipid ratio is high, then the alpha lipo-protein is low and the beta lipo-protein is high. That chemical condition of the blood is probably atherogenic[12] in man as well as in animals. This does not necessarily cause deposits but it is at least an indicator that severe atherosclerosis is present.

It is evident from Table 2 that something in certain animals and humans prevents the development of the atherogenic blood picture. When a male is given estrogens, his blood picture changes and approaches that of the young female. Barr recently reported a case of severe xanthomatosis in which the yellow deposits disappeared on estrogen but returned when the estrogen was discontinued. It will be noted that normal dogs are particularly resistant to atherosclerosis but when (with thiouracil and high cholesterol feedings) atherosclerosis develops, the dog's blood then shows alpha lipo-proteins as low as those of a man after an attack of coronary thrombosis.

Our findings in Hawaii seem to add support to these experiments and to the idea that animal fat in the diet may be a very important factor in developing severe atherosclerosis. The old Japanese got 80 per cent of their calories from rice. They also ate soybean products. Stigmosterol comes from soybeans. Kinsell showed that stigmosterol can keep the blood cholesterol values from rising. Per-

[9] Willius, F. A., Smith, H. L., and Sprague, P. H.: A Study of Coronary and Aorta Sclerosis: Incidence and Degree in 5,060 Consecutive Post-mortem Examinations, Proc. Staff Meet. Mayo Clinic 8: 140 (Mar. 1) 1933.

[10] Ahrens, E. H., Blankenhorn, D. H., and Tsaltas, T.: Effect on Human Serum Lipids of Substituting Plant for Animal Fat in Diet, Proc. Soc. Experi. Biol. and Med. 86:872 (Aug.-Sept.) 1954.

[11] Kinsell, L. W., Partridge, J., Boling, L., Margen, S., and Michaels, G.: Dietary Modification of Serum Cholesterol & Phospholipid Levels, Jour. Clin. Endocrin. and Metabol. 12:909 (July) 1952.

[12] Barr, D.: Some Chem. Factors in the Pathogenesis of Atherosclerosis, Circulation 8:641 (Nov.) 1953.

TABLE 2.—*Comparisons of Per Cent of Alpha Lipo-proteins and Total Cholesterol.*

	NO. OF SUBJECTS	% TOTAL CHOLESTEROL IN ALPHA LIPO-PROTEINS		TOTAL CHOLESTEROL
		Mean	*Range*	*Mean mgm %*
Normal dogs	14	82.9	76.0-91.4	167
Normal rabbits	2	52.7	50.8-54.6	41
Human infants (cord blood)	27	43.3	28.7-61.0	65
Normal women (age 18-35)	20	43.3	22.2-46.1	187
Normal men (age 18-35)	24	25.2	13.3-39.4	197
Normal women (age 45-65)	20	23.4	11.7-38.4	252
Normal men (age 45-65)	21	22.9	12.4-40.7	239
Young diabetics (age 4-35)	19	19.1	5.6-37.7	254
Survivors of myocardial infarction	85	14.1	5.6-30.4	258
Atherosclerotic rabbits (Kellner)	3	9.6	7.0-16.4	364
Familial xanthomatosis	6	7.1	3.2-14.0	459
Atherosclerotic dogs (Kendall)	6	5.8	1.1-8.1	2698
Nephrotics	12	5.1	1.8-8.7	577

haps that was an added advantage in the Oriental diet.

The American diet contains 40 per cent animal fat. Keys[13] noted that our diet in 1933 obtained 33 per cent of the calories from fat, but in 1940, 40.2 per cent came from fat. Today, 42 per cent of the calories come from animal fats. The American arterial tree has grown stiff too soon and apparently faster than that of other nations. There are now numerous reports in the literature to support the suggestion that it is diet and not race that makes the striking differences in the atherosclerosis found.

There was an amazing drop in arterial deaths in Sweden, Norway, and Finland[14] during the dieting war years, whereas, in Denmark there was no drop in such deaths. The Danes had to eat their butter, eggs and milk, since they could not ship them out. Higginson and Repler [15] gave an excellent report on the age groups and coronary disease from Rhodesia and Uganda. Atherosclerosis was rare in men under 50 and absent in women. Those people ate a low animal fat diet. The Walker *et al.*[16] report on the Bantus with their low cholesterol and few post-mortem arterial changes, on a low animal fat diet, adds another plus mark for this argument. He also mentions the low fat diets and low coronary incidence reported from Italy, Japan, Spain, China, India, Belgian Congo, and other places. Very recently Keys and Paul White[17] returned from Sardinia and from South Africa where their studies added still further evidence of the same type. Keys, in many previous reports, has helped to stir us from our smugness about the wonderful American diet.

If we would try to stop this eating ourselves into early incapacities and uncomfortable old age, we seriously must consider changing our national diet. Irving Wright[18] says "most if not all evidence of senility is secondary to atherosclerosis." If we can keep this part of our circulation from aging, we can make retirement at 65 seem ridiculous. The evidence for animal fat's being a cause of death is more definite than the relationship of smoking to lung cancer.

Atherosclerosis (the cause, at least, of the severest symptoms of the aging circulation) is a pathologic condition that begins early, increases during the course of years, and is present in 100 per cent of both Orientals and Caucasians by the time they reach the age of 65. Our findings[8] suggest that the younger Orientals, who for the past thirty years have been eating the Caucasian diet high in milk, butter, eggs, and animal fat, and lower in the soybean products, are now developing a more severe type of atherosclerosis. A recent 35 year old Chinese patient with coronary thrombosis (verified by E. K. G.) said he loved and ate lots of butter, cream and fatty meats. This process, an important part of an aging circulation can probably be influenced as to its severity, and many of its clinical expressions could thus be prevented by diet.

The experience in Hawaii seems still to show a real difference in the clinical expression of this arterial condition, as between the Caucasian and the Oriental. Of 5,254 admissions of Orientals to the Queen's Hospital in Honolulu, 19 were for coronary disease. During the same time, 4,565

[13] Keys, A.: Atherosclerosis, Jour. Mt. Sinai Hospital, N.Y.C. 20: 118 (July-Aug.) 1953.

[14] Malmros, H.: The Relation of Nutrition to Health, Acta Medica Scandinavica Supp. 246:137 (June 13) 1950.

[15] Higginson, J., and Repler, W. J.: Fat Intake, Serum Cholesterol Concentration & Atherosclerosis in the South African Bantu, Part II, Atherosclerosis & Coronary Artery Disease, Jour. Clin. Investig. 33: 1366 (Oct.) 1954.

[16] Walker, A. R. P., and Arvidson, U. B.: Fat Intake, Serum Cholesterol Concentration & Atherosclerosis in the South African Bantu, Part I. Low Fat Intake and the Age Trend of Serum Chol. Concen., Jour. Clin. Investig. 33:1358 (Oct.) 1954.

[17] Keys, A., and White, P.: Verbal Report at 1955 American College of Physicians Meeting in Philadelphia.

[18] Wright, I.: Vascular Diseases in Clinical Practice, 2nd Ed., Year Book Publ., Chicago, 1952, pg. 100.

TABLE 3.—*Relation of Blood Pressure to Age and Nationality in Workers on Sugar Plantations in Hawaii.*

	TOTAL TESTED	UNDER 45	H.B.P.	PER CENT	OVER 45	H.B.P.	PER CENT
Filipino	429	207	37	18	222	74	33
Japanese	428	190	17	3	236	80	34
Caucasian & Portuguese	136	81	7	9	55	15	27
Puerto Rican	60	36	1	9	24	6	25
Hawaiian & Part Hawaiian	66	44	8	18	22	15	70

Caucasians were admitted, but 75 of them for coronary disease (3.5 per 1,000 admissions, to 16.4). As time goes on and our present young Orientals grow older on the Caucasian diet, we will expect this expression of severe coronary atherosclerosis to equalize in the two races.

Someone always mentions the Eskimo during a discussion of atherosclerosis, and asks since he eats so much blubber, why doesn't he have lots of coronary diease? Dr. K. Rodahl,[19] who is undertaking research on this point in Alaska, said it is true that the Eskimo almost never has high blood pressure. But x-ray and other studies indicate that the Eskimo probably has as much atherosclerosis as does the Caucasian. However, he said, the Eskimo seems emotionally very calm and never gives the impression of suffering from arterial deterioration. He added that until more study and more autopsies have been done, this answer cannot be given. The chemical analysis of the blubber the Eskimo eats (about 40 per cent of his calories do come from animal fats) has been reported to have a chemical constitution that may be different from our animal fats, i.e., unsaturated fatty acid rather than saturated. Dr. Rodahl said that the studies they have made indicate blood cholesterol and the amount of Sf 12-20 are the same as those found in Caucasians. However, in due course of time the full answer on the Eskimos will be given.

A study recently of 1,122 routine blood pressure examinations on plantation workers gave the results shown in Table 3. This problem is also related to the aging circulation. Those with high blood pressures eventually tend to have more atherosclerosis, and high blood pressure is, at least in women, an etiologic factor in coronary occlusion.[20] This factor in the aging circulation is not caused by atherosclerosis, but it may increase its severity.

B. M. Cohen[21] reported that in a series of 1,140 American Indians he found only 1.02 per cent of males and 1.2 per cent of females with high blood pressure. The Indians apparently have been kept away from the stress of civilization. Our racial groups, in the midst of strikes, comics, automobiles, TV, and an American diet as part of their daily struggle, show a high percentage with high blood pressures. Beyond the age of 45 there does not seem to be much difference in the various racial groups as far as blood pressure is concerned. The high figure for a relatively small group of Hawaiians is interesting, since they tend to have more fat individuals than do other groups. We considered all readings up through 150/90 as normal.

A clinical survey study by Boas[22] of 343 men and 225 women, all over 40, reported 25 per cent of the men and 37 per cent of the women with high blood pressure, very much like the proportions obtained on plantation workers in Hawaii. As a contrast, a report from Mexico (ages not given) noted 2 per cent of the poor and 18 per cent of the private patients with high blood pressure. The comment was made "the *mañana* attitude seems to protect the working class."[23] Emotional tensions and blood pressure do seem to have a causal relationship in many cases.

Finally, the most tragic part of the aging circulation is the symptoms produced by cerebral arteriosclerosis and brain atrophy. The latter condition is not always caused by circulatory changes. Yet when our blood pressure problems are prevented or corrected, for which the new drugs and the new concept of the relationship of animal fats to atherosclerosis give us some hope, this phase of the aging circulation may be greatly reduced.

[19] Rodahl, K., Director of Research Arctic Aeromedical Laboratory, Personal Communication.

[20] Master, A. M.: Hypertension and Coronary Occlusion, Circulation 8:170 (Aug.) 1953.

[21] Cohen, B. M.: Arterial Hypertension Among Indians of the Southwestern United States. Am. J. Med. Sc. 225:505 (May) 1953.

[22] Boas, E. P., and Epstein, F. H.: Prevalence of Manifest Atherosclerosis in a Working Population, Arch. Int. Med., 94:94 (July) 1954.

[23] Chavez, I.: The Incidence of Heart Disease in Mexico, Am. Heart Jour. 24:88 (July) 1942.

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JAUNDICE DUE TO METHYL TESTOSTERONE THERAPY

THOMAS S. MIN, M.D., Honolulu

THE INCREASINGLY widespread use of methyl testosterone in the past few years has given rise to another condition to be considered in the differential diagnosis of the jaundiced patient, namely the jaundice resulting from methyl testosterone therapy.



DR. MIN

Werner in 1947 reported the first case and since then 19 other cases of methyl testosterone jaundice have been reported in the literature.[1] With increasing awareness of this complication the diagnosis will undoubtedly be made much more frequently.

All of the cases reported followed a similar course: jaundice appearing after use of methyl testosterone in doses of 20 mgm daily or more, laboratory evidence of an obstructive type of jaundice with little or no hepatocellular damage, and gradual but complete recovery after withdrawal of the hormone. The following case history illustrates the typical pattern of this illness.

Case Report

A 48 year old oriental man was admitted to The Queen's Hospital on June 24, 1954 with symptoms of anorexia, epigastric discomfort and dark colored urine of six days' duration and pruritus and clay colored stools for three days before admission.

He had been in good health until six months before, when he developed easy fatigability, malaise, occasional hot flushes, insomnia and marked decline of libido. When placed on testosterone therapy, first parentally and then on methyl testosterone lingual tablets, these symptoms rapidly subsided and he felt quite well again. Three months later he discontinued the medication and noted a relapse, so for the two months prior to admission he again took methyl testosterone in the dosage of 20 mgm daily, which he continued until the time of hospitalization.

Physical examination on admission revealed a jaundiced oriental man in no particular distress except for pruritus. The temperature, pulse, respirations and blood pressure were normal, and the only abnormality noted other than the icterus was a moderately enlarged and tender liver.

Laboratory studies revealed a normal blood count. The urine was positive for bile and also positive for urobilinogen in 1:20 dilution. However, a repeat urine examination three days later was negative for urobilinogen. The total serum bilirubin was 8.4 mgm %, alkaline phosphatase 4.1 Bodansky units, cholesterol 340 mgm % with 57% esterified. Prothrombin time was normal, Kunkel 1.6 units, and cephalin flocculation negative in 48 hours. Three stool specimens were negative for occult blood.

Thus, with the exception of a normal serum alkaline phosphatase level, all evidence pointed to an obstructive type of jaundice and surgical exploration was strongly indicated.

However, because of the recent history of methyl testosterone therapy a needle biopsy of the liver was first done and the microscopic report was as follows:

Histological examination of tissue from liver reveals an area in which there is dilatation of the bile canaliculi. There is biliary retention with bile thrombi here and biliary retention in some cells. There is no disruption of hepatic architecture. Minimal triaditis is present. A bile duct appears normal. There is some anisocytosis with enlargement of cells, but this is minimal. The picture is that of methyl testosterone (cholangiolitic obstruction?) jaundice rather than an out and out obstructive jaundice.

The patient subsequently made a steady though slow recovery and on July 31, 1954, or approximately six weeks after the onset of the jaundice, the total serum bilirubin was 1.3 mgm % and he was again complaining of loss of libido, fatigue, etc.

Discussion

The actual mechanism whereby methyl testosterone produces jaundice is unknown. Through some hepatic dysfunction there is apparently produced a disturbance in the normal hydration of bile. As a result biliary stasis occurs in the intralobular ducts with formation of bile thrombi which cause plugging and dilatation of biliary canaliculi. This characteristic microscopic picture was first described by Werner and was considered diagnostic of methyl testosterone jaundice. Quite recently, however, two other widely used drugs, methimazole[2] (Tapazole) and chlorpromazine[3] (Thorazine) have been found to produce this identical type of jaundice.

Summary

A case of jaundice arising from methyl testosterone therapy is presented.

Read before the ninety-ninth annual meeting of the Hawaii Medical Association, May 5, 1955.

[1] References appear in author's reprints.

1230 S. Beretania Street.

RECOGNITION AND HANDLING OF ACUTE EYE EMERGENCIES

C. W. TREXLER, M.D., Honolulu

MANY ACUTE eye emergencies in Hawaii end in blindness. Six hundred and eighty-one are registered with the Bureau as industrially blind, though this is incomplete. There is hope that this will decrease due to acceptance of medical recommendations for safety and care contributing to sight conservation and better job performance.

Glaucoma

Whatever the etiology, neglected or ill treated cases comprise 8 to 15% of blindness. Acute cases may terminate in absolute glaucoma. Recognize such symptoms of sudden onset, severe pain, loss of vision and contracted fields, increased tension, inactive widely dilated pupil, even nausea and vomiting. Administer:

M.S. ¼-½ gr. for pain.
Miotics: Eserine, pilocarpine to reduce tension. Diamox 500 mgs. I.V. or 250 mgm tid reported to dramatically reduce tension. Hastily summon an oculist as surgery is usually needed.

Acute Iritis

This disease differs from acute glaucoma in that vision is better, pupil contracted, tension low, and while cornea is clearer, exudates or cells are often in the anterior chamber and on descemet's membrane.

Atropinize early and fully. If adhesions of the iris have formed, atropine powder or 10% neosynephrine and foreign protein may be urgently needed. (Typhoid paratyph. vaccine 20-40 million I.V. may be used in ascending doses to bring temperature to 103° F. Contraindications to the latter are tuberculosis, debility and high blood pressure or heart disease.)

Bee Sting of the Cornea

The cornea area affected shows a hard boiled egg appearance giving intense pain, blindness, lacrimation, discomfort. Remove the stinger if still present. Instill 2½% cortisone in castor oil every hour. Prescribe cortisone, sedatives and antibiotics as required.

Crown Flower Keratitis

Crown flower milk on the cornea causes almost immediate blindness, but is more alarming than serious. Cortisone and phermanite with phenocaine ointments and bandage for a short while, coupled with reassurance, promotes rapid recovery.

Hysterical Blindness



DR. TREXLER

This likewise requires reassurance. It presents a problem where psychoneurosis, malingering, head injuries and fright, tax the ingenuity, especially in an emergency. Here a psychiatrist, employing sodium thiopental intravenously ascertains the veracity, determines the cause and effects a cure.

Sympathetic Ophthalmia

This may result from laceration or operation of the uveal tract, as the ciliary body, or may follow herpes zoster. The operated (or injured) exciting eye does not respond well to treatment and the fellow eye becomes sensitized, painful, inflamed, watery, with showers of cells in the anterior chamber. Best treatment is prophylaxis. ACTH, cortisone, I.V. foreign protein, and antibiotics are to be tried, unless it is believed vision cannot be restored, requiring early enucleation of the offending eye.

Foreign Bodies

Extra-bulbar foreign bodies are well tolerated in the lids but poorly in the cornea. The latter often harbors metal, glass, sand, etc., detected macroscopically or by binocular loupe. Stain with fluorescein 2% (alkalinized). Anesthetize with ½% pontocaine and remove with a spud. A 20 gauge long-beveled needle is excellent and subsequent use of a dental burr should completely remove a rust ring. Use electromagnet when feasible. Be especially careful in not causing the foreign body to enter the anterior chamber. Use 5% sulfathiazole ointment and pressure bandage in all deep foreign body cases to promote healing and rest. Penicillin and tetanus toxoid may be used advantageously.

Intraocular foreign bodies are of most serious

Read before the ninety-ninth annual meeting of the Hawaii Medical Association, May 5, 1955.

import, are never well retained and often terminate in blindness. Dense ones are seen and localized by x-ray, others macroscopically or with the ophthalmoscope. Those in anterior chamber may be removed through the site of entry or by keratotomy when enmeshed in the iris. Results are often very good.

Those piercing the lens cause cataract and predispose to infection and glaucoma; through the ciliary body, sympathetic ophthalmia; through retina or choroid, hemorrhage and detachment. A posterior sclerotomy just behind the ciliary body is the safest for extraction. Tetanus toxoid 1 cc, antibiotics, complete bed rest, and vitamins C and K are excellent emergency measures. Both eyes are bandaged. Treat complications as they arise.

Contusions of the Globe

These arise from direct or indirect eye trauma as by foreign bodies, blows, blasts and blows upon or fracture of the head. Vision is disturbed for distance; accommodation for near. Temporary myopia with ciliary muscle spasm and deep scleral injection may be the only abnormal findings.

Hyphemia when extensive covers the iris and may require repeated paracentesis of the cornea.

More serious are rupture of cornea, lens, choroid and sclera with extensive hemorrhage and detachment of retina.

If iris is incarcerated cut it off flush. Suture the cornea and use conjunctival flap. A very soft eye with much loss of contents must be enucleated.

Never treat a contused eye lightly, as delayed hemorrhages, retinal tears and separations are not infrequent unless there is complete bed rest and expert care.

Injuries of Bony Orbit

Direct or indirect trauma causing fracture and displacement most frequently involve the lower edge of bony orbit and arch of cheek. X-rays assess amount and direction of displaced fractures and presence of foreign bodies.

Proptosis and blindness may be due to fracture and hemorrhage at the superior orbital fissure. A semicomatose patient may have bleeding postnasally requiring a prone position, possibly transfusion.

Early manipulation of fragments gives the best prognoses. All open cases require tetanus toxoid, gas bacillus antitoxins and antibiotics ahead of infection.

Lacerations

A vertical laceration of a lid severing the orbicularis muscle needs early, expert care, with 000 catgut silk sutures to perfectly coapt the margins. Never suture a dirty wound; determine whether foreign body is present beforehand. Use antibiotics locally. A snugly fitting bandage decreases ecchymosis and edema.

Lacerations of the globe when not too extensive may be sutured but if there is blindness and much loss of contents, enucleation is in order.

Burns of Eyelids

Causes are fire, hot fluids, metals, gases, acids, alkalies, etc. These are usually 1st or 2nd degree. Edema and pain are great, necessitating analgesics locally and perhaps morphine, grs. ¼ or ½. Never traumatize or scrub the tissues. A 2% butyn and 5% sulfathiazole ointment with bandage, and antibiotics internally, usually suffice. Preserve local and body fluids, for which plasma intravenously is superior to whole blood.

Burns of Cornea and Conjunctiva

These give greater pain, more blindness and poorer prognosis. Any chemical burn demands immediate irrigation with normal saline or water, whichever is closest at hand, to continue for 10 minutes, forcefully opening the lids, for to vacillate is to promote blindness.

Acid burns, or burns by lewisite or mustard gas, may be irrigated with 2-4% soda solution followed by instillation of acriflavine in olive oil, 1:1500.

Alkali burns are progressively penetrating and boracic acid solution is used to irrigate. Analgesics, antiseptics, and atropine, separating burned surfaces to prevent symblepharon, are important in each case.

Incendiary bomb eye burns are best treated by 1:1000 proflavine oleate, according to Ballantyne.[1]

Lime burns still cause much concern. There is almost immediate chemosis of the conjunctiva and the cornea becomes opaque. One case I now am treating is responding well with irrigations by 4% neutral ammonium tartrate and hydrosulphosol 5% combined with castor oil.

Tear gas burns respond well to irrigation by boracic acid solution and instillations, a solution of 7% sodium sulfite, 18% water and 75% glycerol.

I strongly recommend:

1. Every person should have blood type tattoo.
2. Every person should carry a card listing all drugs to which he is sensitive.

[1] Ballantyne, A. J.: Eye Casualties on the Home Front, Glasgow M. J. 132:180 (Nov.), 1939.

Summary

Experiences in coping with eye emergencies in peace and war have prompted me to enumerate some aspects in their handling by physicians generally.

This becomes increasingly important since Hawaii has been designated a critical area in case of international complications.

Each physician has been assigned a station with which he should be familiar and should stress speed and accuracy in treatment of all emergencies whenever they arise.

Young Hotel Bldg.

Discussion

DR. THOMAS W. COWAN

Mr. President, members of the Association and guests:

This is the age of cans and concentrates, and apparently this progress has now extended over into our profession. Dr. Trexler has taken the meat from a good many articles on ocular injuries, has condensed them very adequately and presented them to you in small compact cans. This meat has been gathered from many, many sources, he has given it careful consideration, has weeded out the unimportant facts and has saved you all a considerable number of hours for you to try to put down what he has given to you in a very short time.

I have nothing further to add to this discussion. I would like to take the privilege of diluting one of his cans for a short moment and give you some practical points on the treatment of extraocular foreign bodies. Probably of all the eye injuries which you treat in your office, these make up a good share.

A good many of the foreign bodies of the eye are lodged in the upper lid in a small sulcus which is there, and if an individual comes in complaining of a foreign body and you cannot find it in the cornea, evert the upper lid and look in this sulcus. Sometimes with good magnification, you can see a very fine particle lodged here which is the seat of the trouble. It is a good policy to always take the vision before you attempt to remove any foreign body of any magnitude in an eye, be it small or large, and take the vision following the completion of the case when the patient returns. This will save you a good many heartaches because it is surprising how many individuals designate the time of their lost vision to the coincidental occurrence of a foreign body which you have taken care of. It goes without saying that it is necessary to have a good light and excellent magnification to remove most of the foreign bodies which you find in the eye.

If a magnetic or metallic foreign body is lodged in the cornea, unless you have very high magnification and very good light, do not attempt to remove all of the rust which forms around these foreign bodies. You will do damage to the epithelium far in excess of what would happen if the small amount of rust were to remain. This, however, does not hold if the foreign body is directly in the center of the pupil. Then if you find you cannot adequately remove this rust, I do suggest that you send it to someone who has the proper magnification.

Many times a foreign body is gone from the eye when you see the patient, but the end results are there; that is, the scratching of the cornea. In order to demonstrate this, the cornea is stained with fluorescein, 1%. I do not use the fluorescein solution because of the danger of its contamination with pyocyaneus organism after it has lain around the office for quite a while. It is my policy to dip the ends of small strips of litmus paper in a 5% solution of fluorescein, let them dry, and then seal them up in a sterile container, and when you want to stain the eye, just take one of these small little strips and gently touch it to the anesthetized lids and have the patient blink a couple of times, and enough of the fluorescein solution will come off the litmus paper to stain the eye. This should be washed out with some boric or saline, whichever you have handy, and then look at it with your loupe to see if there is any corneal staining. If there is corneal staining, it is wise to patch the eye for at least twelve hours. The constant irritation of the lids over an abraded cornea is disconcerting and painful.

It is not necessary to use Neo-cortef in patching these eyes. Any of the ophthalmic ointments will do, because as you will remember the corneal epithelium, if completely removed down to Bowman's membrane, will heal within six to eight hours. Also, it is necessary to warn these patients, who have rather deeply embedded foreign bodies, that is below Bowman's membrane, that there will always be a demonstrable scar. If it is not in the center of the pupil, it does not make any difference, but they should be told about it.

When patching the eye, it is my policy to lay thin layers of moist cotton over the closed lids at first forming rather a mold over the eye so that even though the eye patch which you subsequently put on with scotch tape comes loose, this cotton mold will prevent the eyelids from opening and allowing the cornea to be scratched by the bandage.

Again, I must commend Dr. Trexler for his ability to condense a considerable knowledge of the treatment of eye injuries in such a small space, and I hope that you will appreciate the fact that this entailed considerable work and that what he has presented are the most up-to-date methods of treatment that we have in use today.

DIVERTICULA OF THE ILEUM

Report of a Case Coming to Surgery

J. E. STRODE, M.D., Honolulu

EXCLUSIVE of Meckel's, diverticula of the ileum occur rarely. Those that do occur seldom cause symptoms and if they cause symptoms they are infrequently of sufficient severity to demand surgical intervention. For this reason it seems worthwhile to report a case that necessitated surgery.



DR. STRODE

Incidence

Dr. J. M. T. Finney discussing a paper by Gerster[1] in 1938 said that the incidence of duodenal diverticula was about 2 per cent, of the jejunum about .2 per cent; it occurred so rarely in the ileum, exclusive of Meckel's, that its frequency could not be determined. Kirklin and Weber[2] in a paper on intestinal lesions said that diverticula of the ileum are rare, usually small, and multiple, and devoted no further comments to this condition. Edwards of London[3] in 1936 discussed diverticulosis of the small intestine. He stated that such diverticula are usually multiple, and practically always limited to the upper part of the jejunum, the ileum being effected only in extreme cases.

In 1943 Benson, Dixon and Waugh[4] recorded the experience at the Mayo Clinic from 1909 to 1942 with non-Meckelian diverticula of the jejunum and ileum. Of 122 cases, 17 occurred in the ileum. Eighty-five cases were found at autopsy. Twenty-one were recognized during the course of an abdominal operation, and in only 13 cases had complicating conditions given rise to symptoms. In 44 of the 122 cases, the diverticula were single, 37 in the jejunum and 7 in the ileum. In 49 of the 85 autopsies diverticula occurred in other viscera and in 14 others congenital anomalies were present. Two-thirds of the cases occurred in males and their ages varied from 12 to 91 years.

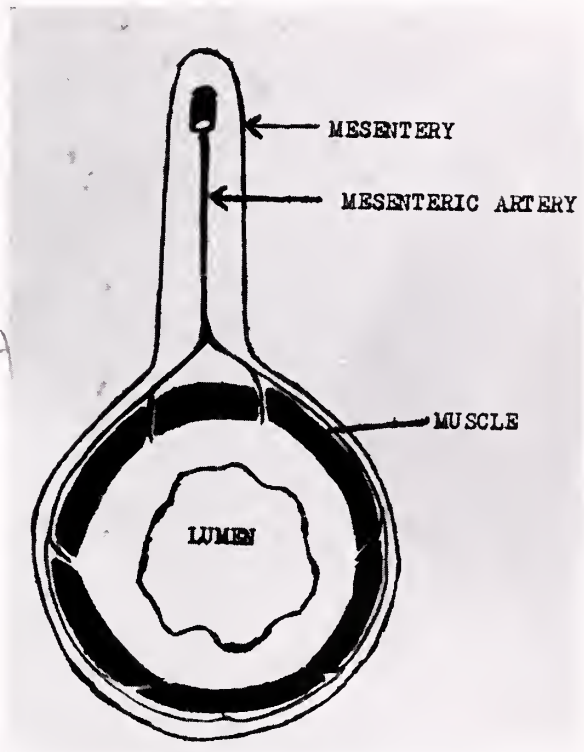


FIG. 1.—Showing arrangement of blood supply to small intestine (after Edwards).

Etiology

Edwards, in speaking of the etiology of diverticula, particularly those of the jejunum, says the constancy with which the diverticula are associated with the blood vessels refutes the possibility of coincidence. After considerable inquiry into the matter, he found that diverticula start just to one side of the mesentery, and this coincides with the perforation of the musculature by the blood vessels supplying the intestines (Fig. 1). Weakness of the muscular wall due to the vascular supply plus increase in intraluminal pressure within the gut, in his opinion, accounts for the formation of such diverticula.

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[1] Gerster, J. C.: Diverticula of the Jejunum, Ann. Surg. 107:783 (May) 1938.

[2] Kirklin, B. R., and Weber, H.: Roentgenological Diagnoses of Diseases of the Small Intestine, Am. J. Digest. Diseases 7:475 (Nov.) 1940.

[3] Edwards, H. C.: Diverticulosis of the Small Intestine, Ann. Surg. 103:230 (Feb.) 1936.

[4] Benson, R. E., Dixon, C. F., and Waugh, J. M.: Non-Meckelian Diverticula of the Jejunum and Ileum, Ann. Surg. 118:377 (Sept.) 1943.

Diagnosis

It has not been found that symptoms of diverticula of the small gut are sufficiently characteristic to suggest such a diagnosis. Constipation, indefinite abdominal pain, flatulence, signs of obstruction and occasionally hemorrhage are too commonly associated with the lesions of the large gut to suggest trouble with the ileum. An acute episode with localized pain and tenderness suggests appendicitis or diverticulitis of the colon, lesions that are commonly encountered.

The only method by which a diagnosis of diverticula of the small gut can be made preoperatively is by x-ray study. Weber[5] stated that the



FIG. 2.—Showing several diverticula in the terminal ileum.

diagnosis of jejunal diverticula is a roentgenological problem. Since the outpouchings are usually large, they are recognized with comparative ease as the contrast media makes its way through the jejunal coils. Frequently the diverticula fail to evacuate the contrast substance rapidly and they are recognizable even after the jejunal lumen in the immediate vicinity has contracted and all but the smallest residue of the opaque substance has been expelled from the mucosal folds. Fig. 2 is an x-ray demonstration of multiple diverticula of the terminal ileum in a male of 34. The examination was carried out because the patient had right sided abdominal distress that had not been relieved by previous appendectomy.

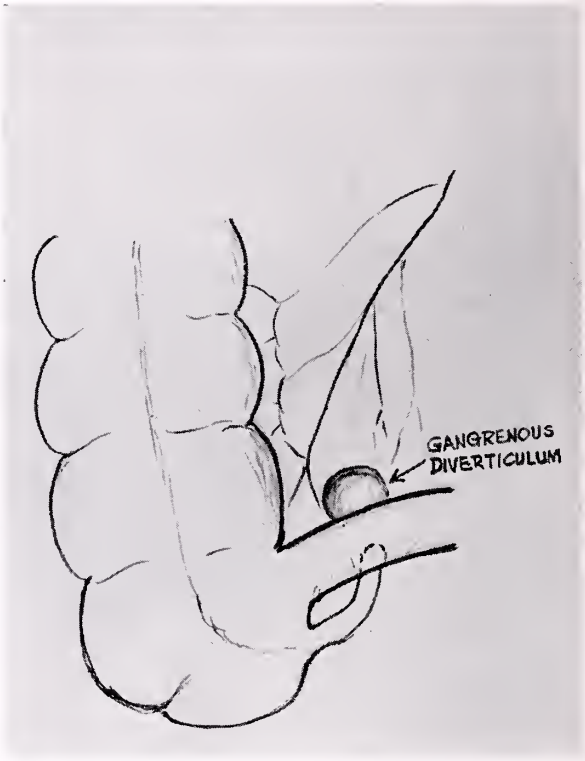


FIG. 3.—Showing location of gangrenous diverticulum in the terminal ileum.

Case Report

A Chinese female, age 57, was first seen on the afternoon of November 23, 1954, complaining of pain in the right lower quadrant in the appendix region. The onset of the pain had been sudden, forty-eight hours previously. At first the pain was in the epigastrium but it gradually localized in the right lower quadrant. On examination there was a palpable mass associated with acute tenderness at McBurney's point. Pelvic examination seemed to be negative. Her temperature was 101.4° F. The white blood count was 12,900 and polynuclear lymphocytes were 93 per cent. The urine showed albumin 4 plus, sugar 4 plus, acetone 4 plus, white cells and red cells a few, coarse and fine granular casts. Blood sugar was 234 mgm per cent. Acetone test on the plasma was negative.

Preoperative diagnosis was walled off ruptured appendix. The patient's diabetic condition was given emergency consideration and she was operated upon shortly after admission to the hospital.

Operative note: Under spinal anesthesia a muscle-splitting right rectus incision was made. There was an inflammatory mass in the mesentery of the terminal ileum, a gangrenous area being visible in the area as shown in Fig. 3. The base of the appendix was inflamed and it was first thought the tip of the appendix had ruptured into the mesentery of the ileum. Further

[5] Weber, H.: Roentgenologic Manifestations of Non-Neoplastic Lesions of the Small Intestine, J.A.M.A. 113:1541 (Oct. 21) 1939.

investigation, however, revealed the appendix to be uninvolved primarily in this inflammatory mass. On exploring the involved area in the ileac mesentery it was found to consist of a gangrenous diverticulum filled with feces. The diverticulum was excised. Microscopic examination by frozen section revealed only inflammatory reaction.

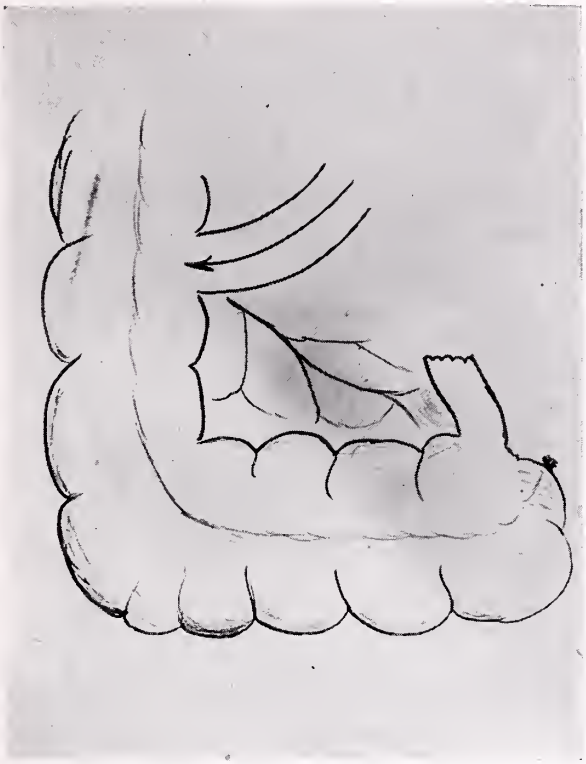


FIG. 4.—Method of dealing with the diverticulum.

Due to so much inflammatory reaction in the terminal ileum and the area of the cecum, it did not seem advisable to attempt closure of the opening in the gut or resection of the ileum and reimplantation of the ileum in the region of the cecum. The ileum was severed proximal to the diverticulum. The distal end was closed and an ileotransverse colostomy performed (Fig. 4). The appendix was removed. One million units of penicillin in 50 cc. of saline were deposited about the cecum and the area was drained. The patient made an uneventful recovery.

Summary

Diverticulum of the ileum is encountered rarely. It is more frequently observed in the autopsy room than in the surgical amphitheater because it seldom produces symptoms. Symptoms when produced are usually mistaken for a lesion in the colon, or (when pain and tenderness are localized to the right lower quadrant) for appendicitis. Only by x-ray visualization can a preoperative diagnosis of diverticulum of the ileum or of any part of the intestinal canal be made.

A case of acute diverticulitis of the terminal ileum is reported in which the condition was mistaken for acute appendicitis.

Straub Clinic, 1020 Kapiolani Street.



CLARENCE E. FRONK, M.D.

The President's Page

This, my first contribution to our bi-monthly JOURNAL, will not be devoted to medical problems, but to some of the spiritual aspects of life—especially religion. Poor indeed is the man who has no religion. There is little else that distinguishes him from the beasts of the field. Civilization was founded upon it. Without religion there would have been no civilization. Mankind in his upward gropings has at times wandered far afield, but always he has struggled back to it. Do not lose faith in your religion. Cling to it, for on religion and its teachings hangs the only hope for the betterment of the world.

May I also bring to your attention some of the philosophic facts of life which can be easily substantiated from records of the past and present? The world is not going rapidly to Hell and Ruin as so many of the older people and a few of the younger ones believe. It is all too easy for the older generation to remember the good things of the past and forget the bad. Let us take a look at the religious statistics: During the Revolutionary War 7% of the people were active church members; 17% during the Civil War; about 30% during the Spanish-American War; World War II 52% and today 62%. Church membership has increased at twice the percentage rate of the general population.

This upsurge of religion is moving forward at a tremendous rate and is entering every phase of life, and none more noticeably so than in medicine. Go to any local church you will, and you will see many, many of our physicians and their families taking a prominent part in the life of the church. I have just returned from a trip covering the perimeter of the mainland. I attended many and varied meetings. There was *not one* that was not opened by prayer, and at the Blue Shield and Blue Cross meeting in Chicago, the President's address was more religious than professional.

We as physicians are more and more acknowledging that we and our medical learning are only instruments in the hands of God.

At the meeting of the American Medical Association at Atlantic City on June 7, 1955, President Dr. Elmer Hess led the doctors at the inaugural ceremony in a program called "Medicine's Proclamation of Faith." He shared speaking honors with Norman Vincent Peale, D.D. Both of these addresses were broadcast over 345 radio stations.

I am a profound optimist. I am growing old in body, but I hope not in mind and vision. To me a man begins to grow old and has lost his usefulness when he says for the first time, "This is the way we used to do it," when he refers to the "good old days" or to any specific time in the past as one of "normalcy." To me there never were any "good old days." We are living in them now.

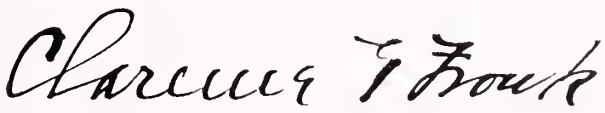
Again, No! the world is not going rapidly to Hell—it's growing better at a most rapid pace. A national weekly just recently ran a series of articles on youth delinquency—the author was asked the question—"Are our youths of today worse than their grandfathers or great grandfathers?" His answer, "Very slightly in percentages, but in total numbers, yes." Did you know that we of today drink only about one-fourth as much alcohol per capita as our forefathers of 100 years ago, and only about one-half as much as 50 years ago? A police report of very recent date states that crime in Honolulu is up 15%. The same paper stated also that over 4,000 youngsters belong to the 4-H Clubs. As people grow older they tend to forget the bad and remember only the good.

Nearly all of the agencies for the Betterment of Mankind have come within my life time. Religious organizations for young people: Y.M.C.A., Y.W.C.A., Red Cross, Boy Scouts, Girl Scouts, Gideon Society, DeMolay, Rainbow for Girls, the many Catholic organizations, Social Service, Social Security, Pensions, Labor Unions, Child Welfare and Child Labor Laws, Minimum Wages, Fair Labor Laws, the breaking down of color lines, the League of Nations, and the United Nations. More and more man is thinking, "What can I do for my fellow man?"

Unfortunately, perhaps, man's technology has progressed much faster than his spiritual growth. Man as a civilized creature has developed within a comparatively short time. He came into being probably three million years ago, but civilization began only twelve thousand five hundred years ago. The veneer of civilization is very thin, and is easily broken through. We are mere infants in our social and spiritual climb upward.

And now a few brief words about our own medical profession. No group in the world of comparable size can match us in professional skill. With the possible exception of one or two of the very latest medical or surgical procedures, no patient need look beyond the shores of Hawaii for better help. Just as we have kept abreast in our professional life, so we have led our entire nation in the method of applying that skill. This has been accomplished only with much travail. At no time have we all seen eye to eye. That too is a good omen. Any good psychiatrist will tell you that it's time to call for his help when the parents and children in a large family don't work up a good fight once in awhile. I like to see every committee have one member on it who is against everything that the other members propose. It keeps the other members from being too complacent. I have tried to keep abreast of the inside workings of many state, national and lesser societies. In none, after the fury of the disagreements are over, is there as little professional jealousy, and as much goodwill and real friendship, as exists among our members.

We must recognize the fact that medicine and its method of practice is changing as rapidly as the other sciences—more so than many of them. That the business, political and social world is in an upheaval and moving forward at a tremendous pace. Let each of us help to guide the destiny of our profession as successfully in the future as we have in the past.



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[EDITORIALS]

But to None Others

The teaching of osteopathy was once conducted as irresponsibly, in scores of unrelated, non-standardized schools, as is that of naturopathy or chiropractic—or as *was,* only a few decades ago, that of allopathic medicine. Now osteopathy is taught in but six schools, and these have an intensive four-year curriculum which includes all of the subjects taught in orthodox schools of medicine—as well as the "osteopathic concept" and the "musculoskeletal lesion."

These schools have acknowledged that their training program is substandard, hampered by lack of funds, clinical facilities, clinical material, and good teachers. They have expressed a desire for doctors of medicine to help in their teaching program.

An investigative committee of the A. M. A. headed by Past President John Cline, of San Francisco, after studying this question for three years, recommended that this request be granted, on the dual ground that (1) cultism (the teaching of the "musculoskeletal lesion") was a very minor part of the teaching in osteopathic schools, and (2) the need to raise the standards of medical care of the estimated 7% of our population receiving its medical care from osteopathic physicians was a very real need and a proper responsibility of the medical profession. The committee recommended that the American Medical Association declare it "not unethical" for its members to teach in osteopathic schools, if asked—and if not forbidden to do so by their state or county societies.

Four members of the Reference Committee on Medical Education and Hospitals, to which this committee report was referred at the Atlantic City meeting in June, said they were not completely convinced that osteopathy was no longer cultist in its teaching, but nevertheless recommended adopting the principal provision of the report. A minority report by one member, however, recommending that A. M. A. members not be allowed to teach in osteopathic schools until and unless the American Osteopathic Association and the schools first disavow, and cease to teach, the "osteopathic concept," was adopted by the House of Delegates, by the narrow margin of 101 to 81.

A major consideration in rejecting the majority report was the fear that its adoption would give great impetus to the osteopaths' efforts to achieve legal recognition comparable to that accorded regular physicians and surgeons, in those states, notably Illinois and Kansas, where they have been restricted to the use of osteopathic manipulations in the treatment of the sick. In Illinois the Supreme Court has already decided the issue in favor of the osteopaths.

One specious argument against the committee's recommendation was a quotation from the Hippocratic Oath:

> I will impart a knowledge of this Art to . . . those bound by a stipulation and an oath according to the Law of Medicine, but to none others.

It appears that roughly 7% of the sick in the U. S. A. receive all or much of their medical care from approximately 11,000 osteopathic physicians. If the training of these physicians is, and continues to be, below par, this care is, and will continue to be, substandard. How much the care rendered by osteopaths now in practice could be improved by post-graduate education is anybody's guess; not

much, perhaps, but some. The possibility of improving the quality of the care which will be rendered by the present students in osteopathic schools can hardly be denied.

It seems to us that it is as much the responsibility of the A. M. A. to try to improve the quality of that care, by improving the osteopathic schools' teaching facilities—now that we have been invited to do so—as it was fifty or a hundred years ago for us to try to improve the quality of training in our own schools of allopathic medicine. To shirk this responsibility merely because these schools still teach a concept for which we feel the evidence is wholly inadequate—namely, the "musculoskeletal lesion"—is unworthy of our professional ideals and ethical standards. The A. M. A. has, in its care to avoid any association with cultism, done a disservice to the public whose well-being it professes to place above all other considerations.

Fluoridation

House Joint Resolution 66, giving permission to add fluorides to the drinking water in Hawaii for the purpose of reducing Hawaii's shockingly high rate of tooth decay in children, passed both houses of the Twenty-Eighth Legislature by about a 3:1 vote, and was pocket-vetoed by Governor Samuel W. King on May 28 on the ground that it was "controversial" and should be studied further before being given legislative approval. In effect, the Governor used the old Hawaiian device of voting *kanalua,* or "doubtful."

In view of the fact that the prevention of tooth decay by fluoridation of drinking water has been known to be effective since 1939,[1] and has been more intensively studied since that time, under both natural and artificially imposed conditions, than any other public health measure that has ever been proposed[2]; and in view of the free public discussion given to it in Honolulu during the past two years, culminating in public hearings before the legislature at which virtually every medical, dental, scientific and educational group in the Territory spoke strongly in favor of it, it seems difficult to justify the Governor's veto on any ground except the political one—and even from this standpoint, its wisdom seems doubtful.

The eleven original articles and reports contained in the third A.A.A.S. Monograph[2] summarize (as of 1951 to 1953) our extensive knowledge of fluoridation of drinking water for the prevention of caries, and confirm what ordinary commonsense observation of experience in cities like Grand Rapids (which has had fluoridation for nearly 11 years now) so strongly suggests: fluoridation is highly effective, and absolutely harmless.

The cost of fluoridation is trivial—even in Honolulu, where thirteen sources of drinking water must each be treated individually. It amounts to roughly 10 to 20 cents per family per month for the first year to pay off all installation costs, and 10 cents per family per month for maintenance. It is wasteful, of course—only a small fraction of the fluoridated water is actually consumed by the children. But at this low cost, what does it matter? The fact is that all of the abundant available evidence fails to give support to any of the numerous alternative methods that have been tried. Home fluoridation, suggested repeatedly (oddly enough, too, by many of the same people who loudly proclaim its wholly imaginary dangers!), could never be carried out continuously enough (since children drink a good deal of water away from their homes) to do the job, even if one supposed that mothers could add to their present duties the task of maintaining a continuous supply of the proper concentration of fluoride in the house. And anyone who does suppose this is being extremely naive.

There are those "rugged individualists," still swallowing the camel of compulsory education and vaccination and straining (proudly!) at the gnat of prevention of preventable but non-communicable disease, who maintain that a child's tooth decay is the child's (or perhaps his parents') own business, and insist that no adult should be required to drink fluoridated water (and pay for it) merely to reduce the incidence of tooth decay in his or another man's children. They are living in a by-gone day. Today, people are too closely integrated with one another, socially and financially, for this attitude to be tenable. *Every* child's tooth decay costs *every* citizen money. Each child's tooth decay is *every* citizen's business. "Send not to seek for whom the bell tolls. It tolls for *thee.*"

Don't Condemn Cutter

The Cutter Laboratories, in Berkeley, have been manufacturing biologicals for nearly sixty years. Their reputation is attested by their being chosen as one of the firms to manufacture Salk vaccine—an honor they might well regret having received.

They invested hundreds of thousands of dollars in the manufacture of poliomyelitis vaccine, close to a million dollars altogether—and, with the other participating firms, would have lost it all had the Francis report been an adverse one.

[1] Dean, H. T., Jay, P., Arnold, F. A., Jr., McClure, F. J., and Elvove, E.: Domestic Water and Dental Caries, Including Certain Epidemiologic Aspects of L. acidophilus, Pub. Health Reports 54:962, 1939.

[2] Shaw, J. H.: Preface to Fluoridation as a Public Health Measure, Amer. Assn. for the Advancement of Science, Washington, D. C., 1954.

Cutter vaccine was one of the first released, and some of it went to highly endemic polio areas, where susceptibility of the population may well be supposed to have been maximal. Hawaii had only Cutter vaccine for use in the schools, and we administered 5,300 doses of it. One case of post-inoculation polio occurred, five days after vaccination; it was a fulminating, fatal case, and Type I virus was recovered from the child's central nervous system.

The national picture was not good. As of May 27, 113 cases of polio had been reported following vaccination, and 47 cases in parents or siblings of inoculated children. Of the 113 cases, 69 occurred among 293,000 children receiving Cutter vaccine, 29 among 2,250,000 receiving Lilly vaccine, 11 among 580,000 receiving Wyeth vaccine, and 2 each from Pitman-Moore and Parke, Davis products.

All the manufactured vaccine has been tested now and declared safe, except for two lots of Cutter vaccine. Just what is wrong with these lots, and why it went wrong, has not been disclosed, if it is known. There will be no further release of vaccine for commercial use until the NFIP contract is filled.

Meanwhile, please reflect that 1 tragic accident out of 5,300 inoculations in Hawaii—or 59 such incidents out of nearly 500,000 on the mainland—as compared with 90 out of 422,793 inoculations given last year—is hardly justification for condemning a reputable 60-year-old firm. Don't, like the King of Hearts in Alice in Wonderland, put the sentence before the verdict. Let's wait and see.

Bound Volumes or Microprints?

The costly and inefficient preservation of medical literature in bound volumes on library shelves has very properly been brought under attack by R. H. Kampmeier, Editor of the *Southern Medical Journal*, in a recent editorial.[1]

He estimates that it costs about $425 to acquire, bind and store each volume for a period of 50 years. At an average of close to two volumes a year, this means an expenditure, for large libraries, of well over $6,000 a year to keep most of the 500 U. S. medical journals alone. And paper won't last forever, as he points out.

[1] Kampmeier, R. H.: How Can We Preserve Our Medical Literature? (Editorial), South. Med. J. 48:399 (Apr.) 1955.

Compact reprinting of many medical journals is being widely carried out today, but in a haphazard fashion, with microfilm, microcard, and microprint vying with one another. Each requires a different magnifying reading device. None covers the entire field of medical literature.

Dr. Kampmeier holds no brief for any of the available methods of concentrating our medical literature, but he urges strongly that the American Medical Association assume the responsibility for bringing some order out of the existing chaos before it is too late. He suggests that a Council on Medical Literature and Libraries should be formed to take on this job. We warmly second this sensible and timely suggestion!

"Herpes" and "Lupus"

"Herpes" means just one thing to a dermatologist—yet it means something quite different to the non-dermatologist. To a dermatologist, it means only "herpes simplex"—the cold sore or fever blister disease. To a non-dermatologist, it means "herpes zoster." The dermatologist, on the other hand, would never call herpes zoster "herpes"; if he's going to shorten this name, he shortens it not to "herpes" but to "zoster." The language is growing, but it's hard to say in which direction. However, the dermatologists are on the same side as the virologists, and would appear to have the better of it.

The same confusion has arisen in recent years with regard to lupus erythematosus, largely since the identification of systemic L.E. with Osler's erythema multiforme with visceral manifestations. Non-dermatologists are prone to abbreviate "lupus erythematosus" not to "L.E." but to just plain "lupus"—something no dermatologist would do. When a dermatologist says "lupus" he means only "lupus vulgaris." Those dermatologists who do want to abbreviate lupus erythematosus or lupus erythematodes to something besides "L.E.," drop the noun rather than the adjective, and call it "erythematodes," but never "lupus." Two syllables are easier to handle than six, and lupus vulgaris is pretty uncommon in the U.S.A., and abbreviations like "L.E." might be regarded as *infra dig.*—so it may be that here "lupus" will eventually win out. At this writing, however, it's still confusing, and should be avoided.

This is What's New!

How to treat the number one problem in contemporary medicine drives many physicians to distraction. Dr. Schindler, a Wisconsin internist, after recognizing that he could see only one patient a day if he were to adequately treat emotionally induced illness, has tried a new approach. By giving the patient fifteen hours of **directive psychotherapy** by means of **tape recordings** and **lantern slides,** he has effected "cures" more consistently than by any other method he has tried. (*Ann. Int. Med.* [April] 1955).

A New York gastroenterologist finds dilute hydrochloric acid and Acidulin no help in treating symptoms associated with achlorhydria. This investigator also finds the gastrointestinal symptoms in achlorhydric patients entirely nonspecific and much the same as symptoms encountered in patients with hyperacidity, hypoacidity and those with normal gastric secretions. Symptomatic treatment with a **bland diet** and **sedation** appears to be about as good as any form of treatment for patients with functional gastrointestinal symptoms **with or without achlorhydria.** (*New Eng. J. Med.* [May 12] 1955).

Prolonged treatment with chlorpromazine **(Thorazine)** can cause severe agranulocytosis. This usually occurs at about the sixth week of treatment. Cases have been reported from Denmark, Norway, and the British Isles. The most recently reported case expired seven weeks after starting treatment with chlorpromazine. With a total white count of 800 per cubic millimeter, she developed a lobar pneumonia which did not respond to antibiotics. (*British Med. J.* [April 16] 1955).

A 51-piece jigsaw puzzle was solved at Cambridge University last year. [Well, This Is What's *Fairly* New—Ed.] The English biochemist, Sanger, after ten years of intensive work on the **insulin** molecule, has been able to determine the **structural formula.** This represents the first blue print obtained of a complete protein molecule. Next step—synthesis? (*Scientific American* [May] 1955).

The tranquilizing drugs continue to crowd the couch in treatment of psychiatric disorders. **Miltown,** a non–habit-forming central nervous system depressant, was found useful in keeping **alcoholics** sober and anxious patients more relaxed. It appears to be of little value in psychotic states. *J.A.M.A.* [April 30] 1955).

Two Boston surgeons find the mortality rate too high in patients undergoing **cholecystectomy** as an emergency procedure. After finding a **mortality rate of 13 per cent** in patients undergoing an emergency cholecystectomy, they believe, "The acute gallbladder should not be treated surgically without an adequate period of preparation." The problem that still remains in Hawaii. How long is adequate? (*New Eng. J. Med.* [April 14] 1955).

Chloroquine **(Aralen,** Winthrop) and amodiaquin **(Camoquin,** Parke, Davis), which have pretty well superseded quinacrine (Atabrine) in the treatment of systemic lupus erythematosus, seem to be potentially beneficial in a wide variety of **skin diseases,** including most of those for which no specific curative treatment is currently known. So said Dr. Herbert Ratner of Chicago at the recent California State Medical Association meeting.

FRED I. GILBERT, JR., M.D.

Woman's Auxiliary

99th Annual Meeting of the Hawaii Medical Association

The weekend of May 5 through May 8, 1955 proved interesting and entertaining to members of the Woman's Auxiliary.

Thursday evening, May 5, at 7:30, the House of Delegates meeting of the Woman's Auxiliary to the Hawaii Medical Association was held at the home of Mrs. Ralph Cloward, with dessert, coffee, and a social hour for all Auxiliary members from neighbor islands.

Friday morning beginning at 10, the annual membership meeting convened at the Racquet Club, Kailua, with swimming, tennis, and a fashion show featured during the lunch hour.

Saturday evening, the annual banquet featured the traditional nine-course Chinese dinner at Le Roy's.

Sunday afternoon, this being Mother's Day, the ladies were invited to join the men at their annual picnic. The top of Tantalus, the home of Dr. and Mrs. P. Howard Liljestrand, was the setting for the happy conclusion to an eventful week.

Officers elected for the year 1955-56, Woman's Auxiliary to the Hawaii Medical Association, are:

President	Mrs. W. J. Holmes
President-Elect	Mrs. Edmund Tompkins
1st Vice-President	Mrs. John W. Devereux
2nd Vice-President	Mrs. Mitsuharu Hoshino
Recording Secretary	Mrs. A. Leslie Vasconcellos
Corresponding Secretary	Mrs. Douglas H. Murray
Treasurer	Mrs. Harry Arnold Jr.
Members-at-Large	Mrs. Raymond Hiroshige
	Mrs. Walter Quisenberry
	Mrs. Howard H. Honda
	Mrs. Nicholas Steuermann
Delegates to the 32nd Annual Convention, Woman's Auxiliary, American Medical Association	Mrs. W. J. Holmes
	Mrs. Edmund L. Lee
Alternates	Mrs. H. Q. Pang
	Mrs. P. M. Cockett

Mother of the Year . . . Mrs. John W. Devereux

We are pleased and proud that our very own Dorothy Devereux has been recognized by the Retail Board of the Honolulu Chamber of Commerce as the most outstanding Mother of the Year in our community.

In addition to her family duties and activities in the Oahu Health Council, Parent-Teachers' Association, Crippled Children and Adults, and the Salvation Army Girls' Home, she is an outstanding member and worker and one of the staunchest supporters of the Woman's Auxiliary, since the group was organized in Hawaii.

Dorothy is our Parliamentarian, Constitution-Revision chairman, Legislative Committee consultant, and first vice-president of the Woman's Auxiliary to the Hawaii Medical Association.

Doughnuts and Ceramics

June 7, 1955, 9:15 to 10:00 A.M., doughnuts . . . freshly cooked before your eyes . . . were the coffee hour feature offered members and guests of the Honolulu County Auxiliary.

With such a pleasant prelude, the ladies were offered a second treat with Claude F. Horan of the Art Department, University of Hawaii, who made his favorite subject, Ceramics, a living, vital thing . . . capturing the attention and interest of all present.

Roller Skating Party . . . Aftermath

Financially a success, socially, it was great, and from all reports, so enjoyable that a medical family benefit we hope will become an annual event, whether it be a skating party or some other activity.

Neighbor Island Auxiliary Members—Attention!

This page in the Hawaii Medical Journal is yours as well as that of the Honolulu County Auxiliary. Your correspondent would greatly appreciate hearing of your doings so that we may include your news items with ours. Please send communications to 1680 Lewalani Drive, Honolulu 14, Hawaii.

Mrs. Joseph W. Lam

The Honolulu County Medical Library

Mrs. Ethel Hill, *Librarian*
Mrs. Mary Jo Murray, *Library Assistant*
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8:00 a.m.-4:30 p.m., and 7:30 p.m.-9:30 p.m.
Monday through Friday
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Closed all day and evening on National holidays
and at noon on Territorial holidays

Recent Acquisitions

Anatomy and Physiology

Ferrer, M. I., ed. *Cold injury. Trans. . . . 3rd conf., Feb. 22-25, 1953.* c1954. (gift of Josiah Macy, Jr. Foundation)
Fulton, J. F., ed. *A textbook of physiology.* 17th ed. c1955. (gift of publisher)
Hall, V. E., ed. *Annual review of physiology.* v.17. 1955.
Hill, W. C. O. *Man's ancestry.* 1953. (gift of publisher)
Shilling, C. W. *The human machine.* c1955. (gift of publisher)

Clinical Medicine

Leaf, Alexander. *Significance of the body fluids in clinical medicine.* 2nd ed. c1955. (gift of publisher)
Rytand, D. A., ed. *Annual review of medicine.* v.6. 1955.
Selye, Hans. *Fourth annual report on stress.* 1954.
Wakefield, E. G. *Clinical diagnosis.* c1955. (gift of publisher)

Gynecology and Obstetrics

Flexner, L. B., ed. *Gestation. Trans. . . . 1st conf., Mar. 9-11, 1954.* c1955. (gift of Josiah Macy, Jr. Foundation)
Harrison, R. G. *Studies on fertility.* 1954. (gift of publisher)
Netter, Frank. *Ciba collection of medical illustrations.* (The productive system). v.2. c1954. (gift of publisher)
Titus, Paul. *The management of obstetric difficulties.* 5th ed. rev. 1955. (gift of publisher)

Neurology and Neurosurgery

Ecker, Arthur. *Angiographic localization of intracranial masses.* c1955. (gift of publisher)
Kahn, E. A. and others. *Correlative neurosurgery.* c1955. (gift of publisher)
Minz, Bruno. *The role of humoral agents in nervous activity.* c1955. (gift of publisher)
Moore, Sherwood. *Hyperostosis cranii.* c1955. (gift of publisher)

Nursing

Hayes, W. J. *Human relations in nursing.* c1955. (from Nurses' Association)
Jensen, D. M. *Ward administration.* c1952. (from Nurses' Association)
McKenna, F. M. *Thresholds to professional nursing practice.* c1955. (from Nurses' Association)

Orthopedics

Casagrande, P. A. *Fundamentals of clinical orthopedics.* c1953. (gift of publisher)
Lewis, R. W. *The joints of the extremities.* c1955. (gift of publisher)
Rush, H. A. *Living with a disability.* c1953.
Steindler, Arthur. *Kinesiology of the human body.* c1955.

Poliomyelitis

Spencer, W. A., ed. *Treatment of acute poliomyelitis.* 2nd ed. c1954. (gift of publisher)

Psychiatry

Kugelmass, I. M. *The management of mental deficiency.* c1954. (gift of publisher)
Podolsky, Edward, ed. *Management of addictions.* c1955. (gift of publisher)

Surgery

Christopher, Frederick. *Minor surgery.* 7th ed. c1955. (gift of publisher)
Maingot, Rodney. *Abdominal operations.* 3rd ed. c1955. (gift of publisher)

Therapeutics

Alexander, H. L. *Reactions with drug therapy.* c1955. (gift of publisher)
Brockbank, William. *Ancient therapeutic arts.* 1954. (gift of publisher)
Wilkinson, J. H. *Semi-micro organic preparations.* 1954. (gift of publisher)

Tuberculosis

Medlar, E. M. *The behavior of pulmonary tuberculosis lesions.* 1954. (gift of the Hegeman Fund)
Riehl, Gustav. *The therapy of skin tuberculosis.* c1955. (gift of publisher)

Miscellaneous

Directory of medical specialists. v.7. c1955.
Keeney, E. L. *Practical medical mycology.* c1955. (gift of publisher)
Ricketts, H. T. *Diabetes mellitus.* c1955. (gift of publisher)
Wolstenholme, G. E. W. *Preservation and transplantation of normal tissues.* 1954. (gift of publisher)

From the Board of Medical Examiners

Akl, F. M. A. *Surgical technigrams.* c1954.
American College of Surgeons. *Surgical forum. Proceedings . . . forum sessions . . . 39th clinical congress . . . Oct. 1953.* c1954.
Best, C. H. *The physiological basis of medical practice.* 6th ed. c1955.
Bodansky, Oscar. *Biochemistry of disease.* 2nd ed. rev. & enl. c1952.
Campbell, Meredith, ed. *Urology.* 3 v. c1954.

Davidson, Maurice. *A practical manual of diseases of the chest.* 4th ed. 1954.
De Palma, A. F., ed. *Clinical orthopedics.* No. 2 and 3. c1953-54.
Deutschberger, Otto. *Fluoroscopy in diagnostic roentgenology.* c1955.
Douthwaite, A. H., ed. *French's index of differential diagnosis.* 7th ed. 1954.
Fishbein, Morris. *Medical progress, 1954.* c1954.
Fishberg, A. M. *Hypertension and nephritis.* 5th ed. enl. & rev. c1954.
Gonzales, T. A. *Legal medicine, pathology and toxicology.* 2nd ed. c1954.
Green, Morris. *Pediatric diagnosis.* c1954.
Greenhill, J. P. *Obstetrics.* 11th ed. c1955.
Herbut, P. A. *Pathology.* c1955.
Herbut, P. A. *Urological pathology.* 2 v. c1952.
Levine, S. Z., ed. *Advances in pediatrics.* v. 3 & 5. c1948-1952.
Maingot, Rodney. *Abdominal operations.* 3rd ed. c1955.
Nichols, H. M. *Manual of hand injuries.* 7th ed. c1955.
Ormsby, O. S. *Diseases of the skin.* 8th ed. rev. c1954.
Selye, Hans. *Fourth annual report on stress.* 1954.
Slobody, L. B. *Survey of clinical pediatrics.* 2nd ed. c1955.
Titus, Paul. *The management of obstetric difficulties.* 5th ed. rev. c1955.
Wakefield, E. G. *Clinical diagnosis.* c1955.
Yater, W. M. *Fundamentals of internal medicine.* 4th ed. c1954.

* * *

Mrs. Hill attended the meeting of the Medical Library Association, held in Milwaukee, Wisconsin, May 16-20. There were over 260 librarians present from all parts of the country. Visits were made to the new Marquette University Library in Milwaukee, and to the University of Wisconsin Library in Madison. A definite interest in and trend toward planning new medical library buildings was noticeable throughout the mainland.

Leis were presented to the retiring president and incoming officers at the annual banquet, and many enquiries were received as to when the Association might be invited to Honolulu.

On her return trip, Mrs. Hill stopped at the Mayo Clinic in Rochester to see the Medical Library there and was fortunate in meeting Dr. Vernon Jim from Honolulu, who took her on a guided tour of the new Clinic Building. Dr. Jim sends regards to all his friends in Honolulu. Medical libraries in Spokane, Portland and Seattle were also visited by Mrs. Hill.

Umi Makahiki I Hala*

Territorial Insurance Against the Cost of Hospital Care

Round Table Meeting

Mr. Honeywell: Some considerable concern has been felt over the constantly mounting cost of hospitalization. A few years ago the cost was $5 per day. Last year the average of county hospitals was $9.96, of private hospitals $8.49.

Report of the Journal Committee

Exhibit H

With the second issue of this fiscal year, Mrs. Edith C. Bennett replaced Mrs. Elizabeth Bolles as Managing Editor, and the financial report will show how well Mrs. Bennett has succeeded in her new position. At the same time, Dr. E. A. Fennel succeeded Dr. Douglas Bell as ex-officio member of the Advisory Editorial Board.

Our printer, Mr. Watkins, has suggested that beginning with the July-August issue we might do well to transfer the work to a larger and more elaborately organized establishment, such as the Star-Bulletin plant. Negotiations have been begun, but no decision has been reached as yet. It may prove unnecessary to make the change.

Report of the Penicillin Committee

Exhibit P

Final report of chairman Territorial Committee for Distribution of Penicillin to Civilians, July, 1944-March 15, 1945.

In the meantime, thanks for your kokua, and for your patience in your trials and tribulations with the management of distribution of penicillin under the Territorial Committee. It is a pleasure to us as well as to you to know that distribution is not any longer regulated and the need no longer exists. The filing of this report closes the activities of the Territorial Committee for distribution of penicillin to civilians.

* Ten years ago. From Volume 4, Number 6, July-August, 1945.

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Book Reviews

Significance of the Body Fluids in Clinical Medicine.

By Alexander Leaf, M.D., and L. H. Newburgh, M.D., Second Edition, 72 pp., Price $2.50, Charles C. Thomas, 1955.

While this little monograph can hardly be classed as light reading, it probably makes about as simple and clear a presentation as can be made of an increasingly formidable subject.

For the recent medical school graduate, it will serve as an excellent review; for the prospective Board candidate, an invaluable aid in preparing for examinations.

For the rest of us old fogies, I give this warning: Don't touch, unless your digestion is good.

F. D. Nance, M.D.

Ciba Foundation Symposium—Preservation and Transplantation of Normal Tissues.

Edited by G. E. W. Wolstenholme and Margaret P. Cameron, 236 pp. Price $6.00, Little, Brown and Company, 1954.

These papers cover problems of immunity, tissue culture, preservation of non-viable and viable tissues, and experimental and clinical transplantation of tissues subjected to diverse treatments. The tissues discussed are blood, bone, skin, artery, cornea, parathyroid, ovary, testis, nerve and adrenal. Autografts and homografts are primarily considered but casual reference is made to heterografts.

Each paper is followed by references and discussions. Photographs and photomicrographs are of good quality. Statistical graphs and tables are also given in some instances.

As the symposium summarizes recent advances in the preservation and transplantation of various tissues, this book should be of interest to surgeons and other personnel engaged directly or indirectly in this type of work.

Ralph N. Akamine, D.D.S.

Pain—Its Mechanisms and Neurosurgical Control.

By James C. White, M.D. and William H. Sweet, M.D., 736 pp., illustrated, Price $17.50, Charles C. Thomas, 1955.

This is the first complete work on intractable pain and its surgical treatment in the last generation. All facets of the problem from the physiologic to the psychiatric considerations have been adequately reviewed. This is not the work of copyists, but rather of physicians with a wealth of clinical experience and the benefits of these clinical experiences are presented to the reader in an understandable manner. This book is a "must" for the reference library of any one dealing with the surgical relief of intractable pain. For all physicians it will offer a wealth of knowledge in a field which has been slighted in the past. This work is recommended without reservation.

Donald R. Simmons, Major, MC

The Drama of Fluorine, Arch-Enemy of Mankind.

By Leo Spira, M.D., Ph.D., 142 pp., Price $2.00, Lee Foundation for Nutritional Research, 1953.

This is a narrative account of the author's experiences, both personal and professional, with such unrelated complaints as flatulence, ulnar neuritis, stammering, leuconychia and others, all of which he attributes to fluorine poisoning. The source of the fluorine, he says, is aluminum cooking utensils, tap water, and beer. No proof is offered in substantiation of either the presence of fluorine in these sources, or its concentration there, or the causal relationship between the fluorine and the symptoms in question—except that they are said in many instances to have subsided when other utensils were substituted for aluminum ones, and "pure mineral water" was substituted for tap water.

The author's ignorance of some of the most simple and basic facts about fluorine chemistry is amply demonstrated; it is astonishing in a man with his academic degrees. One can readily understand his complaint that the British Medical Association had little time to listen to him. The book is not worth reading, even as a curiosity.

Harry L. Arnold, Jr., M.D.

The Management of Obstetric Difficulties.

By Paul Titus, M.D., Revised by J. Robert Willson, M.D., Fifth Edition, 737 pp., Price $12.50, C. V. Mosby Co., 1955.

Formerly edited by Dr. Paul Titus and now re-written extensively by Dr. J. Robert Willson, this is a manual of reference which any doctor practicing obstetrics can ill afford to be without. It is valuable to the specialist, and particularly valuable to the general practitioner who does obstetrical work and may frequently be in a spot where a consultant is not immediately available. The re-writing of those portions dealing with the use of oxytocics, particularly in cases of prolonged labor, and the addition of the section at the end of the book regarding physiological and pathologic disturbances of the new-born infant make the book far more complete than before. The physiological disturbances occurring so often late in pregnancy are clarified, and many points are brought out in the matter of treatment. The use of antibiotics, newer methods used in the diagnosis of pregnancy, and so forth are incorporated in the book making it a manual which everyone should have in his office regardless of the number of obstetrical cases. It is a text which does not replace the professional consultant, but when a difficult problem presents itself, it will help to prepare the physician in charge to acquaint himself and to be better suited for conference with the consultant at such time as the consultant is called upon. For the doctor in a remote area where no consultant is readily available, the material contained in this book may well help to save many lives.

H. E. Bowles, M.D.

Clues in the Diagnosis and Treatment of Heart Disease.

By Paul D. White, M.D., 186 pp., illustrated, Price $5.50, Charles C. Thomas, 1955.

The art and science of medicine walk hand in hand through this short book in a most engaging manner. One sentence from the introduction may be quoted, "A busy doctor hardly needs to spend much time reading detective stories for his entertainment, for he is faced by many problems of this sort in his daily life." Certainly this book is a "what done it" in the field of heart disease.

There are three chapters which general practitioners and internists should all read. The first is on general clues, and emphasizes above all the importance of the art of medicine in evaluating a patient, pointing out that many important aspects of a patient's appearance, attitudes and history are never recorded on his history record because it is really impossible to do so. The way he answers questions, and his knowledge of his disease, whether real or fancied, must all be evaluated.

Another chapter is that on the x-ray shadow of the heart and great vessels. The illustrations are excellent and here the science of medicine as regards heart disease is excellently presented.

Lastly, therapeutic clues present in a most common sense way important facts we should all keep in mind in treating patients with heart disease. From his many years of clinical experience, Dr. White presents in this short book some extremely important information. I am sure I will be a better detective for having read it.

ALFRED S. HARTWELL, M.D.

Differential Diagnosis of Internal Diseases.

By Julius Bauer, M.D., Second Edition, 987 pp., illustrated, Price $15.00, Grune & Stratton, Inc., 1955.

A brief scanning of this book leaves one with mixed impressions. It is divided into two parts: first, the discussion of leading symptoms, and secondly of leading signs. The text is written in a more or less conversational manner with many interspersed, appropriate, short clinical histories, which makes for easy, interesting reading. However, this also detracts from the book's use as a reference volume, since a discussion of specific signs or symptoms is not easily found. The book contains very few illustrations, charts, or graphs. Much of the medical terminology used is of the old-fashioned variety, and many of the differential diagnostic tests mentioned are out of date.

On the whole, this is an interesting volume for an evening of informative, relaxing reading. Its use as a reference work is definitely limited.

ELMER C. JOHNSON, M.D.

Studies on Fertility.

Edited by R. G. Harrison, M.A., D.M., 151 pp., illustrated, Price $4.25, Charles C. Thomas, 1955.

This book is a collection of papers read at the Conference of the Society for the Study of Fertility in London in 1954, as well as other outstanding papers. All the papers are excellent and are presented in great detail. The majority of the papers are detailed works in research, and as such are excellent for those interested in this phase of the problem. For the clinician, who is primarily interested in the diagnosis and treatment, there are a few good papers. This book is recommended for the specialist with a particular interest in fertility.

GAIL G. L. LI, M.D.

The Behavior of Pulmonary Tuberculous Lesions.

By E. M. Medlar, M.D., 244 pp., illustrated, Hermann M. Biggs Memorial Hospital, 1955.

This book is a compilation of the experimental research in animals and of human necropsy findings from more than 1,000 cases. The author describes the pathologic appearance of human lung tissue from the minimal to advanced parenchymal lesion, the cavity, endobronchial involvement, and the relationship of tuberculosis and bronchiectasis before and following chemotherapy. He demonstrates how anti-tuberculous therapy has given new unsuspected potentialities and behavior of the bacilli as well as the effect upon the morphology of the lesion. Many good colored illustrations are given throughout the entire book to clarify the various essential points.

The problem of tuberculosis is still immense; there are many questions admittedly unanswered by the author, who is one of the few outstanding authorities on tuberculosis and has spent a lifetime on this subject. Here is an exacting and thorough research material prepared for the clinician and surgeon whose greater interest lies in tuberculosis and the welfare and concern of the patient.

STEVEN TYAU, M.D.

Modern Medical Monographs—Gout and Gouty Arthritis.

By John H. Talbott, M.D., 92 pp., illustrated, Price $4.00, Grune & Stratton, 1953.

Like others who have written on this subject, Dr. Talbott feels that the incidence of gout and gouty arthritis far exceeds the frequency of its diagnosis in clinical medicine.

This 80-page monograph brings forth recent advances made in clinical research toward a better understanding of this disease and the improved results of present day therapy. It is worth reading by any physician who is confronted with the differential diagnosis of arthritis in his practice, in light of the optimistic note regarding treatment. The therapeutic efficacy of colchicine remains unexplained.

CHEW MUNG LUM, M.D.

Hyperostosis Cranii.

By Sherwood Moore, M.D., 226 pp., illustrated, Price $10.50, Charles C. Thomas, 1955.

This book represents the culmination of a project begun by the author 20 years ago on a subject already honored by over 200 years of literature. The work is a solid study dealing with every phase of Morgagni's syndrome and its variants. Unfortunately the problem of etiology, pathogenesis and possible role of metabolic and endocrinologic influence which the author approached so systematically and thoroughly have eluded solution; he recognizes, however, in which direction future investigation might be more fruitful. Although theory and speculation are indulged in, the main arguments of the book are supported by an orderly scientific analysis of extensive data. The book should be of particular interest to radiologists, neurologists, psychiatrists and endocrinologists. The format is excellent as is to be expected from this publishing house. Minor typographical errors are noted.

EDGAR S. CHILDS, M.D.

(Continued on page 557)

Bureau of Medical Economics

Are you obtaining maximum benefits from your Bureau of Medical Economics?

Today we have approximately 58% of the Honolulu County Medical Society's membership using the Bureau's facilities. There are three hospitals, four medical laboratories and numerous mainland agencies also using its services. However, there are many available services that are still not being utilized.

First, are you aware that the Bureau has an article in each edition of the JOURNAL and together with this July-August 1955 issue there have been six separate articles? You may say, "Yes, I am aware of that." *But has your nurse or secretary read the articles?* I believe in most cases the answer would be "NO." If such is the case, then I would recommend that the Bureau page in each issue of the JOURNAL be a *must* for your office personnel, including the nurses. Go back and get all of your JOURNALS beginning with the September-October 1954 issue. Review them and then give them to your nurse, secretary and office receptionist to look over. I am sure that they as well as you will find numerous helpful hints to help you in both your public relations and the business end of your practice.

Secondly, are you aware that the Bureau has credit reporting facilities? This means that each new patient who comes to you can be checked through our master file. NOW for the first time you have available a true "medical credit report." A patient may be A number one in the Credit Bureau of Hawaii's files, because he always makes his car, TV, furniture and house payments on time, but his medical bills go on unpaid. Inasmuch as your Bureau deals in medical accounts only, our files will show at a glance who is a poor *"medical"* credit risk.

Of course we realize that you can't refuse medical care even after finding out that a certain new patient is a poor credit risk, but you can write a prescription rather than dispense drugs, you can keep a watchful eye on the account and not let it run up too high, or you can possibly help the patient because of your knowledge of his poor medical credit.

The Bureau has credit reporting forms available for use in your office. Your secretary need but fill in the necessary data and forward it to us. After a check through our files you will be notified of any adverse remarks. (We are fast approaching the 10,000th name in our master file.) I would like to repeat a paragraph from our November-December 1954 article.

> Since we do these things to help prevent bad accounts, it is logical to expect every member to use our collection service when the services of a professional collection agency are necessary. To refer them to a commercial collector deprives the Bureau of a record of these bad accounts which should be in the Bureau's file for the protection of other doctors inquiring about these same debtors.

Another service is the various forms available at no cost. We have on hand promissory notes, collection stickers, credit reporting forms, responsible party information forms and assignment forms. If you haven't taken advantage of these items, it is time that you did.

The success of the Bureau has made it possible to maintain the 33⅓% rates on all accounts except where legal action is required or where the account is forwarded to another agency. (As you know many commercial collectors now charge 50% on all accounts.) It must be remembered that we do not employ a solicitor to go out to your office to solicit your accounts, but we rely only on your awareness of the Bureau and a desire to use our services. We fully realize that commercial collectors call on you constantly for your accounts and in many cases you or your secretary will begin to give them some accounts. I have one specific case in mind where we had received accounts from two doctors and collected over 58% for them, yet we have not received any additional assignments for over nine months. I am certain that they have given in to the pressure of a commercial collector.

We could put a man on the payroll just for the purpose of having him call on you, but it is our firm belief that the Bureau is operated by and for the members of the Society and therefore it is not necessary to try and sell you on your own business unit. We are unselfishly interested in saving the doctor money by reducing the number of bad accounts, rather than in earning a commission on accounts unnecessarily placed for collection.

The following is taken from Theodore Wiprud's "The Business Side Of Medical Practice":

> Services of a collection agency should be employed as a last resort rather than as a first aid. No matter how efficient the agency, the personal element is missing. There are times, however, when employment of a reliable agency is necessary.
>
> Unfortunately, hundreds of unscrupulous collectors are operating in this country. Their methods of obtaining payment of bills are such that no physician having regard for his professional standing can afford to allow them to represent him. They gouge the patient for the doctor's bill, plus interest, withholding not only the interest which they have not been authorized to collect but also a substantial portion of what is due the doctor.
>
> Losses sustained by doctors through their relations with unscrupulous agencies must total hundreds of thousands of dollars annually. There is little protection for the physician who indiscriminately turns his accounts over to every solicitor who comes to his office. If he wishes to avoid difficulties he will make a careful investigation of the reliability of the agency with which he is dealing.

Remember, the Bureau of Medical Economics is the Society's own official business unit—it performs a specialized service for doctors and its procedures are on a professional level. The Bureau and its services are available to every member of the Society. There are no dues to pay, no joining procedures. Your membership in the Society opens the door to the full facilities of the Bureau. Why not review your present policy regarding the Bureau NOW!

R. M. KENNEDY, *Executive Secretary*

HMSA—Its Place in the Community

Major Medical Expense Plan

J. R. VELTMANN, *General Manager*

For the first time since its inception in 1938, HMSA is offering its membership additional coverage through a Major Medical Expense Rider. Major medical expense coverage is designed to take care of catastrophic or prolonged illnesses or catastrophic accidental injuries. This type of coverage has become very popular during the past few years, usually with commercial companies as underwriters. Some companies have withdrawn their program as a result of poor experience, while others have been able to operate successfully. The National Commission of Blue Cross–Blue Shield Plans has conducted surveys and studies relative to this type of program and several Blue Shield Plans are offering this type of protection in conjunction with their basic plans.

Local interest in this type of coverage has been increasing and HMSA has received numerous requests for the development of such a plan. After approximately two years of study and consultation with HMSA's actuary, HMSA feels that it is now in a position to extend this coverage to its members. This was made possible by the excellent experience under our basic plans resulting from fine cooperation from doctors and hospitals and recognition by HMSA members that only by nonabuse can they protect their medical plan. The Major Medical Expense Rider is HMSA's own program, it is not subsidized by Government funds nor is it reinsured through a commercial carrier.

This program is being offered by HMSA simultaneously with the issuance of the Community Group Medical Plan developed by the doctors of Hawaii. Both the Community Group Medical Plan and the Major Medical Expense Rider became available to the public on June 1, 1955. HMSA is encouraged by the response to the Community Group Medical Plan. 100% of the practicing physicians on the Islands of Hawaii, Kauai and Maui have signed as participating physicians of this plan and over 90% of the practicing physicians on the Island of Oahu have agreed to participate in the plan.

In substance, the Major Medical Expense Rider begins coverage where the basic plan coverage terminates and will be offered to qualified HMSA groups with Plan I, the Comprehensive Plan VI, the Extended Benefits Plan or the new Community Group Medical Plan at nominal monthly dues. It offers up to $5,000.00 for physician and hospital services including a $300.00 allowance for nursing services and necessary local transportation and ambulance services. The plan contains a deductible feature between the basic plan benefits and the Major Medical Expense Rider as a sound underwriting feature. The Major Medical Expense Rider covers 75% of medical expenses after application of the deductible amount. The deductible sum represents 5% of the individual or family income with a minimum of $20.00 and a maximum of $500.00. The following is an example of application of the Major Medical Expense Rider:

APPLICATION OF MAJOR MEDICAL EXPENSE RIDER

1. Total Medical Bills	$3,000.00
2. Less Amount paid by basic HMSA Plan	1,000.00
Leaving Balance	$2,000.00
3. Deductible: Paid by Member (5% of Individual or Family Income with Maximum of $500.00 and Minimum of $200.00)	200.00
Still leaving Balance	$1,800.00
4. Major Medical Expense Plan Pays (75% of $1,800.00)	1,350.00
5. Balance to be Paid by Member	$ 450.00

RECAPITULATION

Total Bills	$3,000.00
Total Benefits Paid by basic HMSA Plan and Major Medical Expense Rider	2,350.00
Total Paid by Member	$ 650.00

The example above indicates that the basic HMSA plan and the Major Medical Expense Rider would cover $2,350.00 or approximately 75% of the total expense of a catastrophic illness. The member's balance represents the 5% deductible amount and 25% of the charges for services not covered by the Major Medical Expense Plan. You can readily see the value of such coverage. Combined, the Community Group Medical Plan and the Major Medical Expense Rider enable HMSA to offer one of the most complete medical care programs available anywhere. The success of these plans depends on the continued splendid cooperation of physicians, hospitals and the general membership.

Hawaii Medical Association

Report on A.M.A. Delegates Meeting

Osteopathy, medical ethics, medical practices, extension of the doctor draft law, and polio vaccine were among the major topics of discussion by the House of Delegates at the AMA's 104th Annual meeting held June 6-10 in Atlantic City. From every state in the Union and territory and from several foreign nations, by the end of the fourth day, some 26,767 had registered to see the technical and scientific exhibits, attend scientific meetings, and to watch the procedures of the AMA policy-making body, the House of Delegates.

Principal addresses at the Monday opening session of the House were given by Dr. Walter B. Martin, retiring AMA president, and Dr. Elmer Hess, president-elect. Pointing out conditions under which medicine is practiced as having changed radically, but that the basic philosophy remained unchanged, Dr. Martin declared "our obligation is to bring the best that medicine can offer to the individual patient." Dr. Hess said that the nation's physicians must become leaders in a campaign to "overcome the ravages of mental illness" as well as in an "intensive campaign to eliminate the needless bloodshed" of traffic accidents.

Theme of the President's inaugural program, which had nationwide broadcast coverage, was "Medicine's Proclamation of Faith." Dr. Hess, in this inaugural address, proclaimed that "unless we are willing to give of ourselves and our faith, our science will avail us little." Dr. Norman Vincent Peale, guest speaker on the program, pointed out that "the drawing together of medicine and religion is a step in helping man toward proper use of his God-given potentials and qualifications."

Elected unanimously as president-elect for the coming year was Dr. Dwight H. Murray, general practitioner of Napa, California, who for ten years served as a member of the AMA Board of Trustees, having been its chairman for the past four years.

AMA's 1955 Distinguished Service Award was voted to Dr. Donald C. Balfour, Mayo Clinic surgeon, author and researcher, for his outstanding contributions to medicine and humanity.

The osteopathic issue (highlighted in an editorial in this issue of the JOURNAL) was finally settled by approval of the following statement: That "if and when the House of Delegates of the American Osteopathic Association, their official policy-making body, may voluntarily abandon the commonly so-called 'osteopathic concept' with proper deletion of said 'osteopathic concept' from catalogs of their colleges; and may approach the Trustees of the American Medical Association with a request for further discussion of the relations of Osteopathy and Medicine, then the said Trustees shall appoint another special committee for such discussion."

Liberalization of the Code of Ethics was effected by House adoption of its reference committee report dealing with ten resolutions concerning dispensing of drugs and appliances by physicians. This committee recommended deletion of present Section 8, Chapter I of the Principles of Medical Ethics and substitution of a new title and section as follows:

DISPENSING OF DRUGS AND APPLIANCES

SEC. 8. It is not unethical for a physician to prescribe or supply drugs, remedies, or appliances as long as there is no exploitation of the patient.

Thus in a negatively worded compromise the House disposed of the chronically recurring problems of dispensing drugs, eyeglasses and other appliances, while deleting the question of ownership of drugstores.

Concerning the report of the Medical Practices Committee (set up to investigate and advise on fee-splitting and other dubious practices), despite its reference committee recommendation that the Board of Trustee's condensed version be accepted, the House postponed action, and called for distribution of the entire report of this committee, to all delegates so that more careful study could be made before action at the 1955 Clinical Meeting in Boston.

Unanimous approval was given the recommendation of the Board of Trustees that a 2 year extension of the doctor-draft law be actively opposed. The reference committee's report, which was adopted, was particularly critical of military's utilization of medical officers, majority of whom are "draftees" in caring for servicemen's dependents.

On the Salk poliomyelitis vaccine question, the House took no action on the technical aspects, but re-affirmed its confidence and expressed its gratitude to Dr. Salk for his contribution to medical science. It approved policy statements opposing governmental purchase and donations of the vaccine except where indigents are the sole beneficiaries, and supported production, allocation and administration of the vaccine on a voluntary basis rather than under governmental controls; and inferentially criticized the method under which the initial announcement of its discovery was made.

HOMER M. IZUMI, M.D.
Delegate

ALTERNATE DELEGATE'S REPORT

I went with Dr. Izumi to the June A.M.A. meeting at the suggestion of the Alternate Delegate, Dr. Dodge, to help Dr. Izumi and to learn the ropes. It was an eye-opening experience. I had never seen the House of Delegates of the A.M.A. in action before, and it is an administrative body to be proud of.

I had two long-held impressions pretty strongly confirmed by this experience. First, no doctor ought to resign from the A.M.A. just because he doesn't approve of its policies. He ought to go to the meeting and speak his mind. He will be heard, courteously and at almost any length, in any reference committee meeting where resolutions on which he wishes to speak are being considered. He can introduce any resolutions he wishes through his own state or territorial delegate. He can be heard—and if enough delegates can be brought around to his way of thinking, he can influence A.M.A. policy.

Second, I wasn't much real help to the Delegate except perhaps as an assistant public relations representative for Hawaii, though of course it was an invaluable experience for me in preparation for taking on the job next year. Dr. Izumi has done and is doing a really out-

(*Continued on page 554*)

County Society Reports

Hawaii

The Hawaii County Medical Society met on May 3, 1955 at the Hilo Country Club. A dinner meeting was held. Present were: Drs. William N. Bergin, M. H. Chang, M. L. Chang, H. E. Crawford, R. H. Gray, Walter Griggs, S. M. Haraguchi, C. Hayashi, S. Kasamoto, T. Kutsunai, Walter Loo, Z. Matayoshi, Robert Miyamoto, S. Mizuire, George Oakley, Kay K. Ota, Theodore Oto, G. N. Stemmermann, N. Steuermann, George Tomoguchi, T. D. Woo, Henry Yuen, Gordon Chang and E. Schmidt. Drs. William Kirby, A. Ishoda and L. Ngiralild were guests.

Dr. Theodore Oto, President of the Society, called the business meeting to order and the following business was transacted:

The list of elected officers and committee members is as follows:

President, Dr. Theodore T. Oto
Vice President, Dr. Edwin D. Willett
Secretary, Dr. James A. Mitchel
Treasurer, Dr. Edward Wong
Delegates to Hawaii Medical Association
Dr. Toshio Kutsunai
Dr. Ross H. Gray
Alternates
Dr. John T. Jenkin
Dr. Robert M. Miyamoto
Board of Censors
Dr. Sadaichi Kasamoto (Term expires 1956)
*Dr. Mun Hook Chang (Term expires 1957)
Counselor
Dr. Henry B. Yuen
Legislative Committee
Dr. Robert Miyamoto (Term expires 1956)
Dr. H. E. Crawford (Term expires 1957)
Dr. Toshio Kutsunai (Term expires 1958)
Dr. Grant N. Stemmermann (Term expires 1959)
*Dr. William N. Bergin (Term expires 1960)
Library Committee
*Dr. R. P. Wipperman (Term expires 1956) replacing Dr. Higa
Dr. Walter S. L. Loo (Term expires 1957)
Dr. Richard Hata (Term expires 1958)
Dr. Grant N. Stemmermann (Term expires 1959)
*Dr. Junichi Matsumura (Term expires 1960)
Committee on Scientific Works
Dr. Grant N. Stemmermann
Dr. Samuel Haraguchi
*Dr. Shizuto Mizuire
Public Policies and Grievances Committee
President, Dr. Theo. T. Oto
Vice President, Dr. Edwin D. Willett
Secretary, Dr. James A. Mitchel
Treasurer, Dr. Edward Wong
Counselor, Dr. Henry B. Yuen
Mental Hygiene Committee
Dr. Sadaichi Kasamoto
Dr. Robert Miyamoto
Representative to the Hawaii Chapter of the National Society of Crippled Children and Adults
Dr. Mun Hook Chang
Representative to the Hilo Shippers' Wharf Committee
Dr. H. E. Crawford
Dr. Walter S. L. Loo
H.M.S.A. Representatives
Dr. Archie Orenstein
Dr. George Tomoguchi
Representatives to the Hawaii Chapter of the National Foundation for Infantile Paralysis
Dr. William N. Bergin
Dr. Toshio Kutsunai
Advisory Committee to Maternal and Child Health
Dr. Samuel Haraguchi
Dr. Richard Yamanoha

* Indicates new appointment.

A standard insurance form from the Health Insurance Council was submitted to the Society. This form was accepted by the Society as being suitable for general use.

Drs. Clarence Carter and Shosei Yamanoha were admitted to the Society as Honorary Members. Both of these men were active members until their retirement.

The question arose as to what charge should be placed on immunizations against poliomyelitis. Two plans were discussed—on Oahu the charge is the cost of the vaccine plus the usual charge for any immunization. On Maui the charge is not to exceed $3.00 per injection, including the cost of the vaccine. After a short discussion it was decided to let each physician use his own judgment and conscience in establishing his fees.

Dr. Crawford brought up the problem of the Puumaile Hospital budget. Apparently $50,000.00 has been cut from the hospital budget on monies spent for materials and supplies. The hospital management does not feel that it can operate with this budget cut in view of the fact that it already has the lowest cost per patient in the Territory in this regard. It was decided to have the Legislative Committee convene on May 4, 1955 in order to develop a plan of action.

Following the business meeting Dr. William M. M. Kirby of the Department of Internal Medicine, University of Washington School of Medicine, Seattle, Washington, gave a talk on various aspects of infectious diseases and their treatment.

* * *

The Hawaii County Medical Society met at the Naniloa Hotel on May 26, 1955. The following members attended: Drs. Bergin, Crawford, Jenkin, Kasamoto, Kaufmann, Matayoshi, Miyamoto, Mizuire, Oakley, Okumoto, Orenstein, Ota, Oto, Paynter, Stemmermann, Tomoguchi and Yuen. Drs. Griggs, Paul Brown and Ngiralild were guests.

After dinner a short business meeting was held. Dr. T. Oto appointed the following Hawaii County Medical Society representatives to the Territorial Association:

Diabetes Committee.....Dr. Walter Loo
Cancer Committee.....Dr. S. Mizuire
Chronic Illness Committee.....Dr. S. Kasamoto
Legislative Committee.....Dr. Henry Yuen
Radium Advisory Committee.....Dr. T. Kutsunai

Dr. Oto also revised the membership of the Procurement and Assignment Committee as follows: Chairman, Dr. William Bergin; Members, Dr. C. Hayashi, Dr. H. Okada, Dr. R. Miyamoto and Dr. George Tomoguchi.

Dr. S. Kasamoto brought to the attention of the doctors the necessity of economizing in the medical indigents' program.

Following the business meeting the Society saw two films—one on "Pheochromocytoma" and one on "Poliomyelitis Vaccine."

GRANT N. STEMMERMANN, M.D.
Secretary pro-tem

Honolulu

A special meeting of the Honolulu County Medical Society was called by the president on Tuesday, April 26, 1955 at 7:30 P.M. in the Mabel Smyth Auditorium for several reasons, all relating to the Poliomyelitis Program.

Dr. R. C. Durant presided and approximately 205 members and guests were present.

A special film entitled "Progress Report to Physicians on Immunization Against Poliomyelitis by the Salk Vaccine" was shown through the courtesy of Eli Lilly and Company.

A panel made up of representatives from various groups actively concerned with the program was present to answer any questions. They were as follows:

Dr. J. R. Enright—Territorial Board of Health
Mr. Tate Robinson—Department of Public Instruction
Mrs. Carolyn Patterson—Hawaii Chapter, National Foundation for Infantile Paralysis
Miss Alison MacBride—Hawaii Nurses' Association
Mr. L. H. Hardt—Eli Lilly & Company
Mr. R. M. Kennedy—Honolulu County Medical Society
Dr. R. C. Durant served as moderator

Following the panel discussion the guests were asked to leave and a meeting of the membership was held at which time a standard inoculation fee for the administration of the vaccine was discussed.

The recommendation of the Fee Adjustment Committee was mentioned which in effect was to treat the vaccine like any other normal immunization and that the fee be left to the discretion of the physician. It was also mentioned that the Board of Governors had accepted this recommendation and the question was whether to accept the recommendation or set a standard fee in view of the tremendous interest shown by the public.

A pro and con discussion followed during which it was moved by Dr. Devereux and duly seconded that for good public relations the physician charge no more than $5.00 per single injection. Dr. Chung-Hoon stated that he felt that the charge for the injection should be the usual charge plus the cost of the vaccine given, as recommended by the Fee Adjustment Committee and moved to table the motion before the house. The motion to table was duly seconded and carried with three dissenting votes. Further discussion ensued at which time Dr. J. Palma moved that we charge the usual rate plus the cost of the vaccine which in essence was the recommendation of the Fee Adjustment Committee. The motion upon receiving a second was carried.

There being no further business the meeting adjourned to the lanai where refreshments were served to the members and guests.

* * *

A special meeting of the Honolulu County Medical Society was convened May 3, 1955 at 7:30 P.M. in the Mabel Smyth Auditorium at the request of five members to take definitive action on the recommendations of the Fee Adjustment Committee in regard to x-ray and laboratory charges for use in the new Community Group Medical Plan.

Dr. R. C. Durant presided and approximately 49 members were present.

Inasmuch as copies of the x-ray schedule had been sent through the mail, the meeting was thrown open for discussion. It was objected that the hospitals were already operating at a loss and that the new fee schedule would only cause it to sustain more losses. However, Drs. R. West, N. P. Larsen, Giles and Gaspar reassured the party concerned that that would not be the case as it would be offset by other factors. A question was asked if the Fee Adjustment Committee had made contacts with the hospitals for x-ray and laboratory schedules. It was pointed out that it was not the function of the committee to do so, although the committee does have the different rates of the hospitals and independent laboratories. It was also mentioned that some of the independent laboratories had been approached. Paragraph seven of the proposed schedule (where HMSA reserved the right to review x-ray reports) was also questioned. Again it was pointed out that that particular clause was necessary to protect HMSA from abuses.

A motion was made by Dr. West who moved that the provisions as proposed by the Fee Adjustment Committee be accepted. It was seconded by Dr. Florine. However, it was felt by a few that there were not enough members present to warrant voting on such an important question. A motion made by Dr. Gotshalk to table the motion was defeated.

Further discussion ensued and a motion to move the question was made and seconded. Dr. Chung-Hoon moved to suspend the rules, which motion he later withdrew after some deliberation. The motion was then reread by the chair and put to a vote. The motion carried 21 to 12.

There being no further business, the meeting adjourned.

TORU NISHIGAYA, M.D., *Secretary*

Kauai

The regular meeting of the Kauai County Medical Society was held in the G. N. Wilcox Memorial Hospital Library, April 5, 1955, with Webster Boyden, M.D. presiding.

The following members were present: Drs. Fujii, Ishii, Kuhlman, Kuhns, Masunaga, Rutherford, Wade and Wallis.

The application for membership of James A. Rutherford, M.D., was approved.

Robert Johnston, M.D., Honolulu, T. H., presented an interesting discussion on the subject: "Acute Traumatic Injuries of the Abdomen and Their Management."

* * *

The regular meeting of the Kauai Medical Society was held in the Wilcox Memorial Hospital Library, May 4, 1955, with Webster Boyden, M.D., presiding. Members present: Drs. Brennecke, Fujii, Goodhue, Ishii, Kuhlman, Kuhns, Masunaga, Rutherford, Wade and Wallis. Guests: Drs. Schilling and Iwasa.

W. W. Kirby, M.D., Associate Professor of Medicine, Division of Infectious Disease, Washington School of Medicine, Seattle, Washington, spoke to the society regarding certain aspects of the newer antibiotics; strep throat, rheumatic fever and glomerulonephritis; also information regarding the virus of poliomyelitis and the common cold.

BURT O. WADE, M.D.
Secretary

Maui

The annual meeting of the Maui County Medical Society was held at the Central Maui Memorial Hospital Conference Room on April 19, 1955.

The following members were present: Doctors Rose, Shimokawa, Kanda, Rockett, Wong, McArthur, Totherow, Fleming, Tofukuji, Cole, Sanders, Patterson, Haywood, Ohata, Ferkany, Tompkins and H. Kushi.

Guests present were Doctors Angie Connor, Satoru Nishijima, William Walsh and Maxwell Boyd.

The first order of business was the report of the Nominating Committee given by Dr. Shimokawa. The following slate was nominated:

President: Dr. Louis S. Rockett
Vice President: Dr. Mamoru Tofukuji
Secretary-Treasurer: Dr. James F. Fleming

As there were no nominations from the floor, a motion was made by Dr. Sanders that the nominations be closed and that the secretary cast a unanimous ballot for each of the nominees to his respective office. The motion was seconded and passed unanimously.

Dr. Rockett gave a brief treasurer's report in which he stated that the treasury had started a year ago with $6.95 in the treasury and that the balance at the end of the year was $75.20 with $75.00 in accounts receivable.

A ten-minute educational film sent out by the Mead Johnson Company on the use of "intravenous levulose therapy" was shown after which Dr. Kushi introduced members of the Maternal and Infant Mortality Committee from Honolulu. They were Dr. Nishijima, who acted as moderator, and Doctors Angie Connor and William Walsh.

Dr. Nishijima presented histories of four fatal cases in 1955 to date. After each case, much discussion ensued. The final thought left with the group was "that it would be advantageous to all parties concerned if better case histories were written."

Dr. Wong announced that the H.M.S.A. Community Group Plan would probably start about May 1 of this year. He also stated further that up to the present, about 90% of the physicians of the Territory had been signed up on the H.M.S.A. Community Group Plan although there were 22 still not enrolled.

Meeting adjourned at 10:15 p.m.

* * *

On April 22, 1955 a special meeting of the Maui County Medical Society was called to show the film produced by Eli Lilly and Company on the Salk Polio Vaccine. The movie started at 7:30 p.m. and ended an hour and a half later. A capacity audience filled the Central Maui Memorial Hospital Library. Nurses and other interested people were the guests present.

* * *

A special dinner meeting was called on April 29, 1955 by President Rockett to entertain Dr. Kirby of the University of Washington School of Medicine and transact some business and then have a talk on the uses of the newer antibiotics and culture techniques of viruses.

Members present besides President Rockett were Doctors Otsuka, Patterson, Sanders, Kanda, Ohata, Tompkins, Underwood, Ferkany, McArthur, Wong, Cole, Shimokawa and Fleming. Dr. Kirby and Mr. Harold Boverman, a senior student at the University of Chicago were present as guests.

Dr. Rockett discussed the applications of three doctors for the position of pathologist at Central Maui Memorial Hospital, namely, Doctors Larry Dee, Elmer Pautler, and Clifford Moran. Also, the applications of two others for the position of radiologist, namely, Dr. Otsuka and Dr. Edgar Childs, were discussed. Much discussion ensued during which the general consensus was that the group favored Dr. Moran.

Dr. Ferkany moved and Dr. Underwood seconded that the chair appoint a committee which would be empowered to recommend to the Cancer Society and Mr. Vance the candidates for radiologist and pathologist after first having determined their qualifications. The members voted unanimously in favor of the motion.

Under old business, the question of charges for polio shots was brought up by Dr. McArthur. It was decided by unanimous consent that the charge for polio shots would be no more than $3.00 per shot.

Delegates to the annual meeting were elected. They are Doctors Tompkins and Harold Kushi.

Dr. Ferkany spoke about the Cancer Society's plan for radio question and answer programs. Those recommended on the panel were Doctors Haywood, McArthur and Ferkany. Since everyone agreed the panel stood as moved by Dr. Ferkany.

Dr. Kirby took over the meeting and told an interesting and instructive story about the latest developments in antibiotics. He also touched on viruses and their culture.

At the end of the meeting, Dr. Rockett named the following doctors on the committee for recommending a pathologist and a radiologist: Dr. McArthur, representing C.M.M.H.; Dr. St. Sure, representing Puunene Hospital; Dr. Shimokawa, representing Lahaina Hospital; Dr. Ferkany, representing Kula Sanatorium; and Dr. Ohata, at large.

* * *

After dinner in the Central Maui Memorial Hospital dining room the regular meeting of the Maui County Medical Society was called to order by the President, Dr. Rockett, at 8:20 P. M. on May 24, 1955 in the Hospital Library. Members present besides the President were Doctors Otsuka, Wong, Totherow, Patterson, H. Kushi, Shimokawa, Tofukuji, Underwood, Ohata, Cole, Tompkins, Burden, Sanders, and Fleming. Doctors Izumi, Kanda, and McArthur were late in arriving.

Besides the regular members we had three guests present: Mr. Tom Tagami and Mr. Sam Tanimoto, who represented the Credit Associates of Maui, Ltd., and Doctor Moran who was visiting Central Maui Hospital and looking over the position of Staff Pathologist.

The first part of the program consisted of Mr. Tagami presenting the proposed plans of the Credit Associates of Maui, Ltd. with respect to collecting bills for the doctors. Mr. Tanimoto explained how the Honolulu Medical Economics Board did its work under the management of Mr. Kennedy. Some discussion and questions followed and finally Dr. Tompkins suggested that Mr. Tagami write a resumé of his plans and a questionnaire be sent out to the members of the Medical Society. This

(*Continued on page 554*)

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Notes and News

DOCTORS

Won . . .

. . . a new son-in-law

Dr. Frank Spencer's daughter Suzanne was married on May 14 to Captain John Goldsmith, U. S. Army. His younger daughter, K. K., presented him with his first granddaughter, Kelly, born on March 20.

. . . a community honor

Mrs. John W. Devereux, wife of **Dr. John W. Devereux** and mother of three sons and a daughter, was honored by having been selected Hawaii's Mother of the Year.

Drs. Robert Hunter, W. Harold Civin and **Shoyei Yamauchi** were elected members of the University of Hawaii chapter of the Society of the Sigma Xi, national honorary research organization.

. . . a national honor

Dr. Grover Batten has been honored by election to the James Ewing Society of cancer specialists.

. . . a boy

Mrs. Amelia Bailey, wife of **Dr. Robert Bailey,** became the mother of her fifth child, John Stewart, born on May 8.

. . . a dedication

The Case of the Sunbather's Diary was dedicated by author, Erle Stanley Gardner, to **Dr. Alvin Majoska.** Mr. Gardner's interest in Honolulu's City and County Pathologist arose from the latter's exhaustive scientific work on the mystery "nightmare deaths" among Filipinos in Hawaii.

. . . a big fish

Dr. Homer Benson brought a 450 pound marlin to gaff after two and one-half hours of work.

. . . a tournament

The Tombstone Tournament was won by **Dr. Takeo Fujii,** Honolulu physician.

. . . another girl

Stephanie Ann arrived in the home of **Dr. and Mrs. John M. Felix** on May 26 to join four brothers and a sister.

Addressed . . .

. . . skin men

Dr. Harry L. Arnold, Jr., spoke on Lupus Erythematosus Profundus at the annual meeting of the American Dermatologic Association at Belleair, Florida.

. . . alumni

Dr. Clarence F. Fronk delivered the 7th Annual Alphonse M. Schwitalla Lecture at the St. Louis University School of Medicine in St. Louis, Missouri. He spoke on Medicine in Hawaii, Ancient and Modern.

. . . alumnae

Dr. and Mrs. Steele Stewart spoke to the American Association of University Women of Honolulu on their trip to Italy, Greece, Egypt, and Lebanon.

. . . eye men

Dr. William John Holmes spoke on Hereditary Congenital Ophthalmoplegia before the annual meeting of the American Ophthalmologic Society, at White Sulphur Springs, West Virginia.

. . . dentists

Dr. Nils P. Larsen addressed the joint meeting of the Northern California and Hawaii Dental Societies, in Honolulu. The title of his presentation was Diet and Tooth Decay in Hawaii.

. . . churchgoers

Dr. Grace Hedgecock spoke on the work done for Hansen's Disease patients at Hale Mohalu before the St. Andrew's Guild and Auxiliary of Honolulu.

. . . adventurers

Dr. Robert White described a personal adventure during the Doolittle Raid on Tokyo before the Adventurers Club of Honolulu.

. . . parents

Dr. Roy Ohtani spoke on Children's Health before the Parent Group of the Mother Rice Day Care Center of Honolulu.

. . . hospital helpers

Dr. Harold Civin discussed research projects at the Queen's Hospital before the Queen's Hospital Auxiliary of Honolulu.

. . . citizens

Dr. E. W. Haertig spoke on Some Trends in Preventive Psychiatry before the Mental Health Association of Honolulu.

On Television . . .

. . . for health education

Baby's First Year of Life was presented by **Drs. Richard Ando, G. M. Halpern,** and **John Peyton,** on behalf of the Hawaii Medical Association.

. . . for mental health

Terrible Twos and Trusting Threes, and Frustrating Fours and Fascinating Fives, were locally re-telecast with comments by **Drs. Duke Choy** and **Kay Edgar.**

Travelers . . .

. . . to Atlantic City

Attending the AMA meeting in June, in addition to **Dr. Homer Izumi** and **Dr. Harry Arnold, Jr.,** were **Drs. Edmund Lee, Richard Sia, W. J. Holmes, Abraham Ng Kamsat, Kenneth Ho, R. C. Dusendschon, George Tyau, H. Q. Pang** and **Fred Giles** of Honolulu, **Drs. Marvin Brennecke** and **Patrick Cockett** of Kauai, **Joseph Ferkany** of Maui and **M. L. Chang** of Hawaii.

. . . to San Francisco

Dr. Richard K. C. Lee and **Dr. Leo Bernstein** attended the Civilian Defense meetings sponsored by the United States Public Health Service.

. . . from Korea

Dr. Herbert E. Bawles returned from a visit to Korea as consultant in Obstetrics and Gynecology and advisor for the American Friends Service Committee.

. . . to Mexico and Florida

Dr. and Mrs. Harald Jahnsan toured via Mexico City to Florida, where Dr. Johnson attended the annual meeting of the American Dermatologic Association at Belleair.

HERBERT THOMAS ROTHWELL
1901-1955

Dr. Rothwell was born in Denver, Colorado and received an A.B. degree from Denver University and his M.D. degree from Colorado University in 1926.

After an internship at Mercy Hospital, Denver, and service as house physician at the U. S. Naval Hospital in Boston, Dr. Rothwell came to Honolulu. He served as Resident at Queen's Hospital, 1927-1928, and on January 4, 1929 became the physician of Kahuku Plantation.

Dr. Rothwell was a member of the American Medical Association, the Industrial Medical Association, the American Academy of General Practice; a Fellow of the American College of Surgeons and the American College of Hospital Administrators; a member of the Honolulu County Medical Society, and of the U. S. Naval Medical Corps (reserve). He was also Territorial Public Health Physician, Koolauloa district, and a member of the staffs of The Queen's, Children's and Kapiolani Hospitals in Honolulu.

Dr. Rothwell passed away as the result of an accident at his residence April 14, 1955.

On his arrival at Kahuku in 1929 he found that the hospital was little more than a clinic, poorly equipped, inadequately staffed and lacking in prestige with the local community. With almost missionary zeal he started in to correct this situation, and proved himself an outstanding physician and an exceptionally efficient hospital and medical care plan administrator. His efforts were so successful that within a few years, Kahuku Plantation Company Hospital was given official recognition and certified by the American Medical Association and the American College of Surgeons.

He was very progressive, always seeking more modern ways and methods to improve the quality of medicine in his community. With this in mind, he started offering one year internships in 1937. Five interns were trained by him, the war curtailing his program. Four of the doctors now practice in the Territory.

It can be truly said that Dr. Rothwell dedicated his life to the care of the sick. All those with whom he came in contact learned to respect and revere this truly unselfish man. His memory deserves to be and will be preserved in the hearts of his many friends and residents of Koolauloa for whom he did so much and from whom he asked so little. Dr. Herbert T. Rothwell was a true gentleman and the very essence of the word "Doctor."

P. S. ARTHUR, M.D.

. . . to Portland, Oregon

Dr. Clarence Trexler attended the meetings of the Pacific Coast Oto-Ophthalmologic Society.

. . . to East Asia

Dr. Richard K. C. Lee, President of the Territorial Board of Health, left for an extensive tour of Southeast Asia. The trip is under the auspices of the International Educational Exchange Service of the U. S. State Department. The purpose of the trip is to encourage democratic action abroad through exchange of professional knowledge, and to correct misconceptions regarding the United States.

. . . to Oregon and New Jersey

Dr. and Mrs. H. Q. Pang left for Oregon to attend the graduation of their daughter from Oregon State College. Before returning to the islands, they attended the convention of the American Medical Association.

New Offices . . .

. . . in Washington, D. C.

Colonel Thomas J. Hartford, Commander, Tripler Army Hospital, Moanalua, Oahu, has been appointed Deputy Commander at Walter Reed Medical Center, Washington, D. C.

. . . at Tripler

Calanel John W. Raulston, deputy commander at Tripler, will be interim commander until the arrival of **Colonel John F. Bohlender,** now surgeon for the Fourth Army.

. . . in Kahuku, Oahu

Dr. Andrew Ivy of the Fronk Clinic became physician and surgeon in charge of the Kahuku Hospital when the Fronk Clinic took over its operation on June 1.

. . . in Kaneohe

The Fronk Clinic announces the opening of its Kaneohe Branch at Kamehameha Highway and Pua Inia with **Dr. Robert P. Jay** as the physician in residence.

. . . in Kailua

Dr. Ransom J. Arthur joined the Medical Group's Kailua office, with his practice limited to pediatrics.

. . . at 1611 Bingham Street

Dr. Edgar S. Childs announces the opening of his offices for the private practice of radiology on the main floor of Kapiolani Hospital.

. . . at Waialae-Kahala

Dr. D. Paskowitz and associates and **H. S. Nagahisa, D.D.S.,** announce the opening of the Waialae-Kahala Medical-Dental Clinic at the shopping center.

. . . at Young and Piikoi Streets

Drs. Randal A. Nishijima, Satoru Nishijima, Homer M. Izumi, and **Terua Yoshina** announce the opening of their new offices at the Piikoi Medical Building. **Dr. Nobaru Ogami** also has an office in this building.

. . . at 350 South Hotel Street

Dr. V. C. Waite announces the opening of his new office with practice limited to general surgery, specializing in colonic and ano-rectal surgery.

New Officers . . .

. . . governmental

Dr. Lewis E. Shapiro was appointed Government Physician for the Waianae-Nanakuli District.

. . . fliers

Dr. Charlotte Florine was elected vice-president of the Honolulu Pilot Club.

. . . examiners

Dr. B. Allen Richardson has been appointed a member of the Territorial Board of Medical Examiners.

. . . health department

Dr. Robert Faus is serving as Acting President and **Dr. Leo Bernstein** as Acting Executive Officer of the Territorial Board of Health during **Dr. Richard K. C. Lee's** absence from the Territory.

. . . Sigma Xi

Dr. Harry L. Arnold, Jr., was elected to the Council of the Hawaii Chapter of the Society of the Sigma Xi.

Post-convention Tour

The Hawaii Urological Society sponsored a post-convention tour to Honolulu following the annual meeting of the American Urological Association in Los Angeles. Officers of the local society are, **Dr. R. O. Brown,** President; **Colonel Lou Mantel,** Vice-President; and **Dr. Herbert Y. Chinn,** Secretary.

Maui News

Dr. Dean R. Archer is now in the U. S. P. H. S. His address is Box 1410, Honolulu.

Dr. William T. Kanda and Mrs. Kanda went to the Mainland to attend the graduation of their son, Alvin, from the University of Minnesota.

Dr. Thomas Mar has resigned his position of County Physician at Hana and has moved to Kona, Hawaii.

Dr. J. I. F. Reppun and Mrs. Reppun were on the Mainland for a week to attend the A. A. G. P. convention in Los Angeles early in April.

Dr. Robert A. Rose left Lahaina in June and resumed practice in Southern California.

Dr. William R. Totherow has been helping the Hana residents by flying to Hana three times a week to take care of the dispensary. The Hana folk are fortunate in that some of the doctors have progressed beyond the horseless carriage age.

Dr. James Fleming with Mrs. Fleming attended the graduation of their son, Jim, from Stanford in June.

Harold Boverman, a senior at the University of Chicago School of Medicine, is undertaking a preceptorship in the Territory. He has spent three months with **Dr. Reppun** on Molokai and now will be with **Dr. Fleming** on Maui for a similar period.

NEWS

Postgraduate Courses

A postgraduate course in pediatric allergy under the direction of Dr. Bret Ratner will be conducted by the New York Medical College from November 2, 1955 to May 31, 1956. Limited enrollment is open to applicants who are certified in pediatrics or have met the requirements for certification. Information may be obtained from the Office of the Dean, New York College of Medicine, Fifth Avenue at 106th Street, New York.

* * *

A full-time eight-week comprehensive course in industrial medicine for physicians will be given in the Post-Graduate Medical School of New York University–Bellevue Medical Center commencing Monday, September 26, 1955. Applications should be sent to the Dean, NYU Post-Graduate Medical School, New York 16, New York.

* * *

Fellowships and residencies in the field of malignant diseases are offered by the Texas Postgraduate School of Medicine. Cancer research under able guidance may be undertaken in radiology, pathology, medicine, surgery, and allied fields. For further information, write to Grant Taylor, M.D., Office of Education, The University of Texas M. D. Anderson Hospital and Tumor Institute, Texas Medical Center, Houston 25, Texas.

DONALD RAYMOND CHISHOLM
1905-1955

Friends and former colleagues were shocked to learn of the sudden untimely death of Dr. Donald Raymond Chisholm on April 18, 1955, shortly after his arrival in American Samoa to commence work as Tuberculosis Control Officer.

Born on February 9, 1905, in Halifax, Nova Scotia, Dr. Chisholm received his medical degree from Dalhousie University in 1927, interning at the Victoria General Hospital, Halifax. From 1929 to 1932 he spent two years as Medical Officer for the cable company on Midway Island and a year as a medical resident at Vancouver General Hospital. In 1932 he came to Honolulu for a year's medical residency at Queen's Hospital. From 1933 to 1941 he was a staff physician at Leahi Hospital. In 1941 he became Medical Director of Mahelona Hospital in Kauai, resigning in 1950. Thereafter he was not engaged in the practice of medicine because of poor health, and had lived in California for the past two years.

Dr. Chisholm was licensed to practice medicine in Hawaii in 1932 and was a member of the Honolulu County Medical Society, later transferring to the Kauai Medical Society where he became an honorary member in 1951. He was a Fellow of the American College of Chest Physicians.

Dr. Chisholm was an outstanding clinician, beloved by his patients and highly esteemed by his colleagues for his keen, scholarly mind and broad knowledge of the medical sciences. In early boyhood he became an avid naturalist, an interest he retained throughout his lifetime. During the two years on Midway Island he conducted intensive studies on its birdlife, of which he had a large collection of exceptionally fine photographs.

Dr. Chisholm leaves a wife, Thelma, and two sons, Sterling and Bruce, to whom his former colleagues extend their deepest sympathy.

HASTINGS H. WALKER, M.D.

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Ninety-ninth Annual Meeting

Hawaii Medical Association

HONOLULU, HAWAII
May 5 through May 8, 1955

The annual meeting for the ninety-ninth year of corporate existence of the Hawaii Medical Association—actually only the sixty-fifth annual meeting—was held in the Mabel L. Smyth Memorial Building in Honolulu. The following program was presented:

SCIENTIFIC PROGRAM

The History of Tuberculosis at Kalaupapa Settlement
C. V. Caver, M.D.
Cardiac Arrhythmia Due to Mephenesin
Morton E. Berk, M.D. and A. V. Molyneux, M.D.
Jaundice Due to Methyl Testosterone Therapy
Thomas S. Min, M.D.
Recognition and Handling of Eye Injuries in Emergencies
C. W. Trexler, M.D.
Discussant: Thomas W. Cowan, M.D.
Movie—Conization of the Cervix Uteri with a Simplified Technique
Frank C. Spencer, M.D.
Discussant: W. Harold Civin, M.D.
Medical Uses of Radioactive Isotopes
Jun-ch'uan Wang, M.D.
Plasma Expanders
Edwin J. Pulaski, Col., M. C., U. S. A.
The Detection of Gastrointestinal Bleeding with a Barium-Hydrogen Peroxide Medium
George W. Henry, M.D.
Therapeutic Considerations in the Hypochromic Anemias of Infancy and Childhood
Richard E. Ando, M.D.
Closure of Perforations of the Ear Drum
L. Q. Pang, M.D.
Management of Incarcerated Hernias in Infants and Children
George H. Nip, M.D.
The Scope of Plastic Surgery
Merton H. Mack, M.D.
Duodenal Atresia and Stenosis
Roy T. Tanoue, M.D.
Acid Phosphatase and Prostatic Cancer
Joseph H. Iwano, M.D.
Animal Fat Diet and Atherosclerosis
Presidential Address by Nils P. Larsen, M.D.
Movie—Nephrosis in Children
Recent Advances in Antibiotic Therapy
William M. M. Kirby, M.D., Associate Professor of Medicine, University of Washington Medical School, Seattle

MEETINGS

Council, Wednesday evening, Oahu Country Club
House of Delegates, Thursday and Friday mornings, Mabel Smyth Auditorium
Woman's Auxiliary—House of Delegates, Thursday evening, home of Mrs. Ralph B. Cloward
Annual membership meeting, Friday morning, Racquet Club, Kailua

SOCIAL PROGRAM

Cocktails and annual banquet, Saturday evening, LeRoy's
Breakfast for Golfers, Sunday morning, Oahu Country Club (courtesy of Pfizer Laboratories)
Golf Tournament, Sunday morning, Oahu Country Club
Picnic for doctors and their wives, Sunday afternoon, home of Dr. and Mrs. P. H. Liljestrand

NOTES

Scientific papers presented have been submitted for publication in the HAWAII MEDICAL JOURNAL.

The Golf Tournament was won by Dr. S. R. Wallis of Kauai.

PROCEEDINGS

The minutes of meetings and reports follow:

MINUTES OF COUNCIL MEETING

Wednesday, May 4, 1955 at 6:00 P.M.
Oahu Country Club

PRESENT: Dr. Larsen, presiding; Drs. Chung-Hoon, Fronk, Yee, Richert, Sanders (Maui), H. R. Benson, Yuen (Hawaii), and Gaspar; also Dr. Izumi (AMA Delegate), Mr. Kennedy and Mrs. Bennett.

MINUTES: The Council minutes of May 12, 1954 were approved as circulated.

FINANCES: Dr. Richert presented and explained the budget which had been circulated in the Treasurer's report. He recommended retaining our present auditors, Messrs. Leman and Hough, for another year since their services had been very satisfactory. This was seconded by Dr. Yuen and passed.

Dr. Richert said he would like to see closer cooperation between the Health Education Committee and the Public Service Committee. The chairman read a letter from Dr. Edgar in which the Health Education Committee requested the Council to appropriate $500 for this fiscal year for expenses incidental to monthly TV programs on medical subjects. The TV programs were discussed, particularly in regard to their financing and their possible benefit to the other county societies. The treasurer mentioned that contributions toward these programs had recently been made by Dairymen's, Wyeth and others. The Council believes the monthly TV programs have been very good and the Health Education Committee should continue to produce them. The Council will recommend to the House of Delegates that they request the Public Service Committee to pay from its special Territorial Public Service Fund such sums as may seem advisable and necessary for the production of the TV programs by the Health Education Committee, not exceeding $500 for the year. It was specifically pointed out that the reason for calling on that fund this year was because of especially heavy demands on the Association's budget for the Centennial Celebration and an expensive year for our AMA delegate and alternate with two meetings on the east coast.

The chairman read a letter from Mr. Kennedy stating that the Honolulu County Postgraduate Committee was

planning for postgraduate lectures for 1956. The Committee would be interested in bringing two speakers at the time of the Centennial Celebration and suggested Drs. Neuhauser and Gross of Boston on pediatric surgery and congenital heart disease. Since the Honolulu Society had only appropriated funds for one speaker, they suggested that the Hawaii Medical Association and the Hawaii Cancer Society might be interested in making funds available for the second speaker. Drs. Larsen and Gaspar thought the subjects were not of sufficient general interest for the Centennial Meeting. Dr. Larsen said he had just attended a meeting of the American College of Physicians in Philadelphia and found that a group of the country's outstanding physicians from that organization would be delighted to attend our Centennial and present papers at its sessions if it could take place in the week following the ACP meeting in Los Angeles next April. They would be glad to come at their own expense.

The Council requested Mr. Kennedy to inform the Honolulu Society that the Hawaii Medical Association is unable to participate in bringing these two speakers to Hawaii next year because of the Centennial Celebration and the heavy expense incidental thereto. Since contracts have already been made with high powered men willing to come to Honolulu at that time, the Council feels that an excellent array of speakers, who will attract many mainland doctors, will be available. The Council also suggests that when a team of speakers is brought to the Islands, they should cover a wider field than heart surgery.

On motion of Dr. Yuen, seconded by Dr. Gaspar, the Council approved the budget presented by Dr. Richert. The Council also approved Dr. Richert's recommendation that we follow the Auditors' advice and request the Public Service Committee to invest its unused funds in an interest bearing account.

HAWAII MEDICAL JOURNAL: The Chairman read a letter from Dr. Gotshalk in which he proposed that a Board of Governors for the HAWAII MEDICAL JOURNAL be elected by the House of Delegates consisting of (1) the president of each County Society; (2) the president of the Territorial Association; and (3) eight members of the Territorial Association, to be responsible for the conduct of the JOURNAL and to share the responsibility of its editorial policies.

At last year's Council meeting Dr. Gotshalk had recommended that the JOURNAL follow the editorial organization of *The New England Journal of Medicine.* A letter from that journal outlining its set-up was presented at this time.

After careful consideration of these recommendations, Dr. Chung-Hoon moved that the Council accept the recommendation of the Advisory Board to the HAWAII MEDICAL JOURNAL that its name be changed from Advisory Board to Editorial Board, and further that we accept the recommendation of the Editor and the Board that the JOURNAL be continued on the same basis as heretofore. The motion was seconded by Dr. Gaspar and passed.

It was further recommended that if the Editor finds a suitable candidate for Assistant Editor who is approved by the Council, he shall be appointed by the Council to serve in that capacity.

On motion of Dr. Gaspar, seconded by Dr. Chung-Hoon, the Council appointed the following Editorial Board for the year 1955-56:

Harry L. Arnold, Jr., M.D., Editor
Mrs. Edith C. Bennett, Managing Editor
William John Holmes, M.D., News Editor
Fred I. Gilbert, Jr., M.D., Contributing Editor
Robert A. Kimmich, M.D., Contributing Editor
Clarence E. Fronk, M.D., Editorial Board
Hastings H. Walker, M.D., Editorial Board
Homer M. Izumi, M.D., Editorial Board
James A. Mitchel, M.D., Associate Editor, Hawaii
James F. Fleming, M.D., Associate Editor, Maui
Burt O. Wade, M.D., Associate Editor, Kauai

The Council voiced its heartfelt appreciation to Dr. Harry L. Arnold, Jr. for the invaluable service he has contributed to the Association for the past 14 years as Editor of the HAWAII MEDICAL JOURNAL. As a very small token of gratitude his 1956 annual meeting expenses will be borne by the Association.

CENTENNIAL CELEBRATION: Dr. Larsen reported that he gave an illustrated talk on Hawaii at the American College of Physicians meeting in Philadelphia last month which aroused great enthusiasm among the doctors for a meeting in Honolulu next April after the close of their Los Angeles meeting on April 21, 1956. Dr. Larsen envisions a week of meetings from April 22 through 29 with scientific sessions in Honolulu, visits to the neighbor islands and a pageant in McKinley High School Auditorium depicting the history of medicine in Hawaii. Don Blanding could be asked to help with the pageant and the public could be admitted on payment of a fee. The registration fee was discussed and it was thought the Delegates might leave that to the discretion of the Centennial Committee.

It was moved by Dr. Gaspar, seconded by Dr. Benson, and passed, that the Council invite the American College of Physicians to participate in the Centennial Celebration, and that the Council recommend to the Centennial Committee that the main celebration be held in conjunction with the visit of these outstanding physicians. If possible some outstanding surgeons will also be included.

The Council asked that Dr. Izumi extend an invitation to AMA members to attend our Centennial Celebration and recommended that the Delegates join in the invitation.

There being no further business, the meeting was adjourned at 9:40 p.m.

SAMUEL L. YEE, M.D., *Secretary*

MINUTES OF MEETING HOUSE OF DELEGATES

Thursday, May 5, 1955 at 8:00 A.M.
Mabel Smyth Building

PRESENT: There were 40 present including the following delegates and alternates: Dr. N. P. Larsen, president; Drs. Fronk, Oto (Hawaii), Durant, Samuel L. Yee, Richert, Chung-Hoon, John Bell, Cushnie, Devereux, Ito, Mitsuda, Arthur, R. Benson, Thomas Chang, Gilbert, Edmund Ing, Millard, Quisenberry, Allison, deHay, Morgan, Paskowitz, Berk, Edmund Lee, Sexton, Peter Kim (Kauai), Edmund Tompkins (Maui), Bergin (Hawaii) and L. Q. Pang.

MINUTES: The minutes of the special Delegates' meeting of January 23 and February 6, 1955 were circulated with the annual reports. Dr. Gilbert asked that the minutes of January 23 include a statement that Mr. Kennedy was asked for his comments on the letter to be sent to Mr. Kaiser, but decided that he should not comment because this was a territorial meeting on a territorial matter and he was a county secretary. With this addition, the minutes of both meetings were approved.

ANNUAL REPORTS: Copies of all annual reports had been circulated to the officers, Council members, and Delegates.

ACTION: On motion of Dr. Chung-Hoon, duly seconded, the following reports were approved: Secretary; County Societies; American Medical Education Foundation; Board of Management, Mabel L. Smyth Memorial Building; Cancer, Diabetes Detection (Mr. Kennedy mentioned two cash contributions of $135 and $130 were received as a result of the excellent work of this committee); Hawaii Medical Journal; and Health Education.

In connection with the report of the Medical Plan Committee, Dr. Chung-Hoon asked for the report on various plans which were to be studied by that committee. Dr. Quisenberry, the chairman, replied that they were not yet ready to make such a report. The committee had been investigating the situation and various representatives of HMSA had met with them. Only one action had been taken and it was agreed to include this in the final report. The committee intends to continue its work.

ACTION: Dr. Chung-Hoon moved that the report be accepted and placed on file. Seconded and passed.

ACTION: Dr. Fronk moved that the Emergency Medical Service report be accepted. Seconded and passed.

Commenting on the Professional Services Committee report, Dr. Devereux mentioned that the last remaining sections of the fee schedule had been approved by the Honolulu County Medical Society.

ACTION: The Professional Services report was approved on motion of Dr. Devereux, duly seconded.

Dr. Richert raised a question about overlapping of the Medical Plan, Public Service, Health Education, and the Professional Services Committees. It was brought out that with the adoption of the new Community Health Plan, the Professional Services Committee has completed its work and will not continue to function. It was felt the Medical Plan Committee should continue with the task assigned to them. Dr. Allison said he had served at different times as chairman of both the Health Education and the Public Service Committees. They are both very active, he said, and it would be physically impossible to combine both jobs. Dr. Edgar added that the Health Education Committee has narrowed its efforts to what seems to be strictly education. Perhaps there might be some overlapping of members but both committees are needed.

ACTION: On motions made, seconded and carried, the following reports were accepted: Public Service, Woman's Auxiliary, Legislative, and Advisory Committees to the Bureau of Crippled Children, Day Care Centers, Bureau of Tuberculosis, and Bureau of Venereal Diseases.

STANDARD INSURANCE FORM: The chairman read a letter from Mr. Kennedy about the new standard insurance claim form approved by the Honolulu County Medical Society, requesting its acceptance on a territorial basis. Dr. Fronk said this matter was being considered all over the mainland and this form is better than he saw anywhere else. Dr. John Bell said all the main insurance companies here had accepted it except HMSA. Considerable discussion followed regarding the possibility that HMSA might adopt the same form. Mr. Kennedy spoke of the national form which is much more complicated than the form compiled here.

ACTION: Dr. Bergin moved that the standard insurance claim form be adopted and that the Medical Committee of HMSA be asked to study during the year the feasibility of its adoption by HMSA. The motion was seconded by Dr. Paskowitz and passed without a dissenting vote.

COMMUNITY HEALTH PLAN:

ACTION: Dr. Fronk moved that the new Community Health Plan with HMSA as the carrier be accepted and approved. The motion was seconded and passed without a dissenting vote.

FINANCES: The minutes of the Council meeting held last evening were circulated and read. In relation to the budget a request had been received from the Honolulu County Medical Society that the Hawaii Medical Association and the Hawaii Cancer Society consider making funds available for a second speaker if the Honolulu County Medical Society invited Drs. Neuhauser and Gross of Boston to be postgraduate speakers at the time of the Centennial Celebration. Dr. Quisenberry mentioned that the Cancer Society professional committee would have to consider the possibility of helping to finance these two men. He could not make any commitment at this time.

Dr. Larsen told more about the plan to hold our Centennial Celebration immediately after the American College of Physicians meeting in Los Angeles next April. He had discussed this at the American College meeting just held in Philadelphia and assured us that at least 5 past presidents of the College as well as other leading physicians in the country would be glad to come to Hawaii and participate in our meeting without cost to our Association. Possibly some of these doctors might stay to give postgraduate lectures.

ACTION: Dr. Bell moved that we invite the Fellows of the American College of Physicians to attend and participate in our Centennial Celebration next April. The motion was seconded by Dr. Pang and passed without a dissenting vote.

ACTION: On motion duly made, seconded and carried, the budget presented in the Treasurer's report was adopted.

CENTENNIAL CELEBRATION: It was pointed out by Dr. Chung-Hoon that the Centennial Committee named by the Delegates last year was designated to serve two years.

ACTION: It was moved by Dr. Fronk, seconded and passed, that the Centennial meeting be held during the week of April 22-29.

ACTION: Dr. Devereux moved that the Centennial Committee be empowered to continue planning for the celebration and set appropriate fees for the meeting. Seconded and passed.

ACTION: Dr. Lee moved that Dr. Izumi be authorized to extend an official invitation to AMA members to attend our Centennial meeting (at their own expense). The motion was seconded by Dr. Bell and passed.

VETERANS ADMINISTRATION: Dr. Faus reported that the contract with the V.A. is about to expire.

ACTION: It was moved, seconded and carried that the Medical Association recommend to HMSA a one year extension of the contract with the Veterans Administration.

ADJOURNMENT: Since it was 10 o'clock the Delegates adjourned to reconvene at 8 tomorrow morning.

SAMUEL L. YEE, M.D., *Secretary*

MINUTES OF MEETING HOUSE OF DELEGATES

Friday, May 6, 1955 at 8:00 A.M.
Mabel Smyth Building

PRESENT: Dr. N. P. Larsen, presiding; Drs. Fronk, Durant, Samuel L. Yee, Richert, Chung-Hoon, John Bell, Cushnie, Devereux, Ito, Mitsuda, Arthur, R. Benson, Thomas Chang, Gilbert, Edmund Ing, Millard, Quisenberry, Allison, deHay (acted for Dr. H. M. Johnson), Morgan, Paskowitz (acted for Dr. Devereux until he came to meeting late), Berk, L. T. Chun, Carl Johnsen (acted for Dr. Lowrey), Edmund Lee (acted for Dr. L. Q. Pang until he came to meeting late), Sexton, Bergin (Hawaii), and Peter Kim (Kauai).

MATERNAL AND CHILD HEALTH: A question had been raised concerning the list of obstetrical and pediatric consultants mentioned in the annual report of the Advisory Committee to the Bureau of Maternal and Child Health. Dr. Tom, the committee chairman, said the list was made up of Board men and those eligible for Boards. Dr. Chung-Hoon said the list was seldom used and most hospitals had such lists.

ACTION: It was maved by Dr. Chung-Hoon, secanded and passed that the report af the Advisory Cammittee to the Bureau of Maternal and Child Health be accepted with the deletion af the paragraph entitled "List af Obstetrical and Pediatric Consultants."

RESOLUTIONS: A series of resolutions prepared by Dr. Gilbert, chairman of the Resolutions Committee, was presented to the Delegates.

ACTION: On matian af Dr. Ing, the following resalutian on the death af members was passed by a rising vote:

During the year we have last from aur ranks Dr. Robert N. Perlstein and Dr. Herbert T. Rothwell, active members, Dr. Donald R. Chisholm, honorary member, and Dr. Arthur W. Duryea, a life member.

Since these men all contributed their knowledge, experience and personalities in giving medical care to the peaple of these Islands,

***Be It Resalved* That this Association go on recard as expressing their deep sympathy to the families of aur four members, and that this resolution be spread an the minutes and a copy be sent ta each of the families.**

ACTION: On matian duly made, secanded and carried, the following resolutions were passed:

***Be It Resolved* That the Dairymen's Assaciatian, Ltd., Wyeth, Inc. and Carnation Company who assisted in the TV health educatian pragrams be sent a letter af thanks far their caaperation by the chairman of the Health Educatian Cammittee.**

***Be It Resolved* That the Hawaii Medical Association convey their thanks ta the various cantributars for their prizes far the galf tournament, banquet and picnic and to Pfizer Labaratories far their golf breakfast.**

***Be It Resolved* That the Hawaii Medical Assaciatian convey their sincere appreciatian ta Mrs. Illa Storme and her staff for the excellent jab she has done in managing the Mabel Smyth Building and activities therein during the past year.**

***Be It Resolved* That the Hause af Delegates representing the Hawaii Medical Assaciatian canvey ta the Hawaii Visitars Bureau their sincere appreciatian far their close caaperation with this Associatian during the past year in planning and carrying aut medical meetings here and on the mainland, and especially for sending leis ta mainland doctars arriving here as well as sending these takens af Hawaiian haspitality ta mainland medical meetings.**

***Be It Resalved* That the Hause af Delegates of the Hawaii Medical Assaciatian extend their warmest appreciatian ta the Hanalulu Lei and Flawer Exchange wha pravided leis far dactars arriving here for the Territarial canventians.**

***Be It Resolved* That the Hause af Delegates af the Hawaii Medical Associatian extend ta the Waman's Auxiliary aur warmest alaha far the many many services they have rendered us individually and callectively far the past year.**

***Be It Resolved* That the Hause of Delegates af the Hawaii Medical Assaciation extend their sincere appreciatian to the Honalulu Advertiser, Honalulu Star-Bulletin, Hawaii Times, Hawaii Hochi, FilAmerican Tribune and the New China Daily Press far helping the dactors in these islands in the field af health educatian as well as warking with them tawards canstant impravement of medical care, thraugh the medium of both editorials and news columns.**

ACTION: At the suggestian of Dr. Izumi a resalutian to thank Mrs. Edith Bennett for her services during annual meeting and thraughout the year was passed by a rising vate.

FRIENDS OF THE LIBRARY: The chairman read a letter from the Friends of the Library telling of the importance of the Library of Hawaii to the community and containing two requests: (1) That the Medical Association take a sustaining membership of $10; and (2) that individual doctors be encouraged to take regular $2 memberships and take an interest in the needs and work of the Library of Hawaii.

ACTION: Dr. Chung-Haon moved that the substance of the letter be incarparated in the President's Letter and that the Assaciation take a $10 sustaining membership in the Friends af the Library. The motion was seconded and passed.

SALK VACCINE: Dr. Cushnie raised the question whether doctors in Hawaii should continue to give Salk vaccine and on whose orders the vaccine would be continued. There was a discussion of the developments in the situation to date. It was brought out that there had been no intent on the part of any county medical society or its officers to induce any doctor to give the vaccine unless he was willing to do so. It is entirely a voluntary program. The county societies have worked with the National Foundation for Infantile Paralysis and the Department of Health in carrying out the program and also in suspending it when difficulties arose. Mr. Kennedy said that in view of the questions which had arisen, perhaps the Delegates should go on record as to whether or not this program should continue. After further discussion, it was agreed that this decision should be left to our representatives on the Medical Advisory Committee of the National Foundation and to the Health Department.

ELECTION: Although the roll had been called earlier in the meeting, it was repeated at this time because of latecomers, to be quite sure who was eligible to vote. The following nominations were submitted by the Nominating Committee (Dr. Sakimoto, chairman; Drs. Allison, E. Ing, R. Wong, Vasconcellos, Peter Kim, Harold Kushi and Toshio Kutsunai):

President-Elect: Dr. Webster Boyden
Secretary: Dr. William S. Ito, Dr. B. Allen Richardson
Treasurer: Dr. Louis A. R. Gaspar, Dr. H. Q. Pang
Councillors: Dr. Burt O. Wade, Dr. W. B. Patterson
Delegate to AMA: Dr. Harry L. Arnold, Jr.
Alternate Delegate to AMA: Dr. Samuel L. Yee

Dr. John Bell nominated Dr. Sam Wallis for President-Elect. Dr. Peter Kim said this nomination had been carefully considered on Kauai since the 1957 meet-

ing will be held on that island. Although Dr. Wallis' name was on the original slate of the Nominating Committee, he had withdrawn. Dr. Bell therefore withdrew his nomination.

Dr. Arthur nominated Dr. Richard Dodge for Delegate to the AMA.

The nominations were closed on motion of Dr. Pang, duly seconded.

Dr. Paskowitz raised a question about his being relieved as Dr. Devereux's alternate by the arrival of the latter just before election. The matter was referred to Dr. Durant, but the full quota of Honolulu delegates and alternates were present and Dr. Devereux was entitled to his vote.

The chairman appointed Drs. Millard, Sexton and Richert as tellers. Voting by written ballot ensued.

Dr. Paskowitz asked for the privilege of addressing the Delegates and read a prepared statement concerning the nomination for AMA Delegate.

The results of the election were as follows:

President-Elect:	**Dr. Webster Boyden**
Secretary (for 1 year):	**Dr. William S. Ito**
Treasurer (for 2 years):	**Dr. H. Q. Pang**
Councillors (for 3 years):	**Dr. Burt O. Wade (Kauai)**
	Dr. W. B. Patterson (Maui)
Delegate to AMA (for 2 years beginning Jan. 1, 1956):	**Dr. Harry L. Arnold, Jr.**
Alternate Delegate to AMA (for 2 years beginning Jan. 1, 1956):	**Dr. Samuel L. Yee**

DR. FRONK'S REPORT: While the ballots were being counted, Dr. Fronk reported on the Blue Cross and Blue Shield Conference which he had just attended on the mainland. He stated that the public were determined to have some form of prepaid medical care and it was up to the doctors to provide the best care possible for the lowest cost.

APPRECIATION TO THE PRESIDENT: Dr. Quisenberry moved that a vote of thanks be extended to President Nils P. Larsen, who had guided the Association through a stormy year. The motion was seconded by Dr. Fronk and passed.

MOTHER'S DAY: Dr. Vasconcellos questioned why this year's annual meeting was held on the weekend including Mother's Day. It was explained that this meeting had been set a week earlier, but was postponed because of Dr. Larsen's absence on the mainland where he presented a paper at the American College of Physicians. It was agreed that Mother's Day should be avoided in the future.

ADJOURNMENT: The meeting was adjourned at 10:30 a.m.

SAMUEL L. YEE, M.D., *Secretary*

COUNTY SOCIETY REPORTS

SUMMARY OF ACTIVITIES OF THE HAWAII COUNTY MEDICAL SOCIETY

Grant N. Stemmermann, M.D., Secretary

April—Dr. Jerome Conn talked on hypoglycemia.

May—Dr. Michael Gurdin gave a talk on emergency treatment of facial injury.

June—Dr. Bruce K. Wiseman addressed the Society on the subject of hypersplenism.

The Society endorsed a plan to give its wholehearted support to the comprehensive medical insurance sponsored by the HMSA.

July—Dr. N. P. Larsen presented a series of photographic slides showing interesting diagnostic and treatment problems.

August—Movies were shown on hydrocortone and gastroscopy.

September—A panel of pediatricians and obstetricians met to discuss maternal, neonatal and fetal deaths in this community.

October—Dr. R. P. Wipperman discussed his experiences in field medicine during the Korean War.

November—Dr. J. R. Jacobson addressed the Society on various psychiatric and neurological problems.

December—Dr. S. Mizuire gave a talk on cardiac surgery.

January—Dr. W. Quisenberry gave a talk on the cytology program of the Hawaii Cancer Society.

Following the development of a comprehensive medical insurance scheme by the HMSA, the County Society has voted to accept this scheme unanimously.

March 15—Dr. Lauren V. Ackerman addressed the Society on the diagnosis and treatment of carcinoma.

SUMMARY OF ACTIVITIES OF THE KAUAI COUNTY MEDICAL SOCIETY

B. O. Wade, M.D., Secretary

The Kauai County Medical Society approved or participated in the following activities:

1. Visiting doctors from New Orleans program.
2. Post American Medical Association Convention tour.
3. Voluntary active immunization against tetanus program.
4. Kauai Pregnancy Study.
5. Otologic program for four year olds and similar pilot program in the public schools.

The Kauai County Medical Society held 13 meetings during 1954-55.

The following doctors or group of doctors furnished scientific programs during the same year:

1. New Orleans group—Drs. R. F. Wyler, C. C. Hightower, Sr., D. Bottagles, W. E. Fountain.
2. Dr. Jerome W. Conn, Professor of Medicine, University of Michigan.
3. Drs. Lee and Crowley.
4. Dr. Quisenberry.
5. Dr. N. P. Larsen.
6. Dr. Dorothy Kemp.
7. Mr. Veltmann.

SUMMARY OF ACTIVITIES OF THE MAUI COUNTY MEDICAL SOCIETY

James F. Fleming, M.D., Secretary

Number of regular meetings—7

Number of special meetings—1

New members appointed—

Dr. M. Otsuka, June 8, 1954

Dr. William R. Totherow, October 5, 1954

Dr. Dean Archer, October 5, 1954 (transfer from Hilo)

Dr. Alexander Rose, October 5, 1954

Resignation—

Dr. Sau Ki Wong, June 8, 1954

Guest speakers—

1. Mr. Eugene S. Sheffield—Free Choice of Physicians for Industrial Accident Cases as It Applies to Maui Pineapple Company
2. Mr. Joseph Veltmann and Dr. Faus—HMSA and the Kaiser Medical Plan
3. Dr. Robert Jacobson—Electroencephalography
4. Dr. Paul Larsen—Treatment of Hypertension
5. Dr. Cherry—Abdominal Injuries
6. Dr. Ackerman—Pathology

SUMMARY OF ACTIVITIES OF THE HONOLULU COUNTY MEDICAL SOCIETY

T. Nishigaya, M.D., Secretary

The membership of the Honolulu County Medical Society have had three meetings this past year which included the annual meeting of April 2, 1954, all of which were well attended. A special meeting was held on July 2, 1954, (1) to study the recommendations of the Governor's Advisory Committee concerning House Bill No. 692 and (2) to elect four members to the newly formed Medical Practice Committee.

The annual social event of the year was again held at the Oahu Country Club on November 2 and was an outstanding success.

In May, Dr. Jerome W. Conn, associated with the Division of Endocrinology and Metabolism at the University of Michigan, presented a stimulating series of postgraduate lectures. Dr. Conn's lectures were made possible through the courtesy of the Hawaii Cancer Society.

The scientific and social events of the medical fraternity were particularly accentuated and highlighted this year by the Pan-Pacific Surgical Congress held in Waikiki, October 7-18, 1954.

In accordance with the revised Constitution and By-Laws, the annual meeting of the Society for 1955 was held on December 7, 1954 at which time the officers for the ensuing year were elected.

Since then and to date we have had three regular society meetings and two special meetings, the latter two of which were devoted to Community Medical Plans.

The Society has vehemently expressed its stand against "Panel Medicine" and has voted to accept the new Community Group Medical Plan which was formulated by the Professional Services Committee of the Hawaii Medical Association, amended by the Board of Governors and approved by HMSA.

At present the Society is cooperating with agencies for the administration of the Salk Polio vaccine to children of the first and second grades, a community project well worth supporting.

OFFICERS' REPORTS

REPORT OF THE TREASURER

T. H. Richert, M.D.

We have had a successful year financially. Although there appears to have been a surplus of nearly $4,000, actually $2,500 of this amount was earmarked for our 1956 Centennial celebration. This reserve appears again in the new budget, together with another $2,500, making up the $5,000 total it was decided in 1954 to set aside for our Centennial. We also cleared over $2,000 unexpectedly on our AMA Post Convention held in Honolulu in June, 1954, because it was so much better attended than we anticipated. The expense of sending our delegate and alternate to the AMA meetings was less than we budgeted because they were able to use tourist planes between here and the coast. In this respect we are following the same plan and budgeting first class fares, with the understanding that tourist fares will be used instead whenever feasible.

Following the advice of our auditors, we have invested our reserve funds in savings and loan accounts, with better interest rates than the savings bank. We agree with our auditors that a substantial portion of the public service fund should be invested similarly unless the Public Service Committee has definite plans for its immediate use.

We have found our auditors, Leman and Hough, helpful and satisfactory. We recommend that they be employed for another year.

Those who wish further details concerning our financial situation will find them on file in the Medical Association office. We submit the following budget for the year 1955-56.

	1954-55	Budget 1955-56	
INCOME			
Dues	$10,050.00	$10,600.00	
Journal Advertising	12,536.10	12,600.00	
Journal Sub and Sales	2,527.73	2,530.00	
Annual Meeting	2,463.16	2,500.00	
AMA Post Convention	2,222.90	.....	
Interest	211.56	200.00	
Miscellaneous	181.73	185.00	
	$30,193.18	$28,615.00	
EXPENSE			
Journal	$12,426.00	$12,600.00	
AMA Convention	1,769.44	2,735.00	(1)
Audit	85.00	85.00	
Library	100.00	100.00	
New Orleans Meeting	43.86	.....	
Miscellaneous	265.48	350.00	(2)
Postage	258.30	275.00	
Rental	1,128.00	1,128.00	
Salaries	9,001.50	9,300.00	(3)
Supplies	292.41	300.00	
Furniture	181.25	125.00	
Taxes	228.26	200.00	
Telephone and Telegraph	294.32	350.00	
Travel	136.25	100.00	
Centennial Fund			
1954 appropriation	.....	2,500.00	(4)
1955 appropriation	.....	2,500.00	(5)
	$26,210.07	$32,648.00	

(1) Covers 2 trips to Atlantic City and 1 to Boston.
(2) Includes expenses incidental to Dr. Ackerman's postgraduate lectures.
(3) Includes an increase of $10.00 per month for Mrs. Florence Sueoka beginning May 1, 1955.
(4) Earmarked last year but not yet expended.
(5) As agreed at last year's annual meeting.

REPORT OF THE SECRETARY

Samuel L. Yee, M.D.

The total membership of the Association in all classes is 526, of which 425 (23 more than last year) are paid regular members. By counties this membership is made up as follows:

	Courtesy	Regular	Associate	Retired	Life	Military Service	Honorary	Total, All Classes
Hawaii	1	43				2	3	49
Honolulu		340	58	4	10	8	12	432
Kauai		13				1	1	15
Maui		29					1	30
	1	425	58	4	10	11	17	526

The total number of physicians licensed to practice medicine in the Territory of Hawaii as of April 1, 1955 is 739. Of this number 577 are now residing in the Territory. Of these 543, or approximately 94.1 per cent, belong to the Hawaii Medical Association. [Ed.—*Correction:* Total licensed physicians April 1, 1955 were 644. Of these, 502 reside in the Territory. Of these, 479, or approximately 95.4 per cent, belong to the Hawaii Medical Association.]

We have 397 active members of the American Medical Association and 80 associate members.

COMMITTEE REPORTS

REPORT OF THE AMERICAN MEDICAL EDUCATION FOUNDATION COMMITTEE

Min Hin Li, M.D., Chairman

Realizing the tremendous obligations each physician in this territory bears in the matter of monetary donation here and elsewhere, further drives will be confronted with difficulties.

Though our effort to assist the American Medical Education Foundation is on a "voluntary" basis, it has gone forward from no more than twenty at the end of 1951 to 106 as of December 31, 1954. There is some cognizance of the situation that individual physicians must contribute to the foundation, or directly to his or her medical school, which in turn notifies the AMEF.

Because of our isolation and lack of contact, "voluntary giving plan" is the best means; however, with an increased vigor and reminders, every other month in our fine HAWAII MEDICAL JOURNAL with a card clipped on that particular issue, may help tremendously.

It is not the amount given by each individual physician, but the numbers—as close to 100% as possible, and given perpetually or automatically annually. It can also be suggested that any campaign should be on a county level, each county appointing a chairman to contact as many as possible through personal means, by some doctor who cares and is enthusiastic. As the chairman works without funds or assistance, and as the project is a voluntary one, it should still be continued, because it is worthy of our consideration.

In conclusion, I hope this annual campaign will be continued, so that medical education can remain free and that all medical students who will benefit by our contributions will go into any community in years to come without any taint of obligation of federal subsidy.

REPORT OF THE BOARD OF MANAGEMENT MABEL L. SMYTH MEMORIAL BUILDING

V. C. Waite, M.D., Chairman

It will be recalled that during the past two years, the Mabel Smyth Building has encountered difficulties in obtaining enough income from rentals of office space and auditorium in order to pay routine maintenance costs, and, further, that last year it became necessary to increase the rents for office space occupied by the Honolulu County and Territorial Medical Society offices in addition to the Territorial nursing office. These increases did not meet the demands to keep the building's financial situation solvent; accordingly, attempts were made to find some way in which the Library could pay rental for the space occupied. This latter problem occupied our major concern during the year, and after thorough investigation from every conceivable standpoint, it was finally appreciated by the Board that under the present set-up, it was impossible for the Library to pay a rental fee for its space.

In efforts to obtain extra income, the Board was successful in negotiating with the Nursing Association for the procurement of the Nursing Service Bureau and Physicians' Exchange. In the past, these two activities provided a profit and the Nurses' Association was willing to pass on the responsibility for operation of these two services to another agency. Accordingly, the Nursing Service Bureau and the Physicians' Exchange were transferred to the Board of Management of Mabel Smyth Building on May 1, 1954, and I am happy to report that profits from these two functions have enabled us to adequately maintain our facilities without loss. At the present time, this service is functioning well and is being supervised by Mrs. Illa V. Storme, and I believe that the services for which these agencies were intended are being adequately provided.

During the past year, it has been possible to renovate a part of the furniture in both the lounge and in the Medical Society offices, as well as replacing many of the worn-out venetian blinds throughout the building. In addition, we have obtained a sound-proof enclosure for our projection equipment. In addition, a complete fire inspection was carried out by the Territorial agency and additional fire extinguishers were placed in suggested areas. In November, 1954, the Honolulu County Medical Society voted to grant $100 per month for space occupied by the Library since the local society was by far the most extensive user of this facility.

The Board of Management feels justly proud of the accomplishments indicated above, and at the present time, the continued satisfactory maintenance of our building appears to be assured. Our recommendation at this time is for all health agencies to make use of the services available at Mabel Smyth as much as possible so that it may continue to be an excellent meeting place for the medical profession and related agencies in our community.

REPORT OF THE CANCER COMMITTEE

I. L. Tilden, M.D., Chairman

The Cancer Committee has worked closely with the Hawaii Cancer Society during the past year. As pointed out in the 1954 report of this committee, there is relatively little to do other than co-operate with and guide the efforts of the Cancer Society.

Cytology

The cytologic laboratory of the Cancer Society has continued to function efficiently under the technical supervision of Mrs. Esther Chinn and Mrs. Jean Nishimura. Similar services are now provided on Kauai by Mrs. Kay Hardy and on Hawaii by Miss Gertrude Higa. Slides which contain abnormal cells are examined by a committee of five physicians on Oahu under the chairmanship of Dr. Frank Spencer, and on Hawaii by Dr. Grant Stemmermann.

Professional Education

Dr. Lauren V. Ackerman was brought to Hawaii by the Cancer Society in co-operation with the Hawaii Medical Association to deliver the first Grover A. Batten Memorial Lectures in March of 1955. Dr. Ackerman gave a series of eight lectures to physicians on Oahu, spoke at one public meeting and at a meeting of the Board of Directors of the Oahu Chapter of the Cancer Society, and conducted a joint tumor clinic sponsored by St. Francis, Queen's, Children's and Kuakini hospitals. He also met with the Boards of the Kauai and Maui chapters of the Cancer Society, and spoke to the Kauai, Maui and Hawaii county medical societies. Dr. Ackerman also conducted a tumor clinic at the Hilo Memorial Hospital and participated in a pathology seminar as well as giving one lecture at Tripler Hospital. These meetings were very well attended: 228 persons registered and the average attendance was 107.

Research

The cancer morbidity study conducted jointly by the Hawaii Medical Association, the Territorial Department of Health, and the Hawaii Cancer Society continued during the year. At a meeting of the committee on January 14, 1955, approval was given to a continuation of the study using a simplified form for gathering data. The committee also approved the questionnaire developed by the research committee of the Cancer Society for an epidemiological investigation of gastric cancer. This project had been approved in principle by the delegates of the Hawaii Medical Association at the 1954 annual meeting of the association, and has now been approved by all of the county medical societies. Approval was also given to a project proposed by the dermatologists for the tabulation of cases of skin cancer; this study is now under way.

Summary

I believe that the function of the Cancer Committee of the Hawaii Medical Association should be an advisory one primarily. Active work against cancer should be carried on by the Hawaii Cancer Society and its committees, and not by the medical association. Actually there is a good deal of overlapping in committee membership between these two organizations and the Territorial Department of Health also which is a good feature because it prevents these organizations from working at cross purposes. Our committee has no concrete recommendations other than continued co-operation with the Cancer Society and the Territorial Department of Health.

REPORT OF THE DIABETES DETECTION COMMITTEE

Morton E. Berk, M.D., Chairman

The Diabetes Detection Drive branched out some this past year. The Hawaii County Medical Society with Dr. Woo as chairman did carry on a drive during Diabetes Detection Week. This was the only other county that participated, aside from the Honolulu County drive.

I feel confident that whatever is done in any of the counties it is worthwhile from the standpoint of education, if nothing else. This matter will be the important step for each county to consider and to spend whatever time they can in promoting educational facilities about diabetes, particularly during Diabetes Detection Week. The Honolulu County Medical Society Drive involved testing some fifteen or sixteen thousand people. We have hoped to have the Clinitron machine through the Public Health Service for rapid blood sugar testing. This, so far, has not materialized. I hope it will during the coming year.

REPORT OF THE HAWAII MEDICAL JOURNAL

Harry L. Arnold, Jr., M.D., Editor

The JOURNAL is getting bigger and more profitable. Last year the average issue was up from 82 to 90 pages. Half the increase in size was in advertising (up from 38 to 42 pages) and half in features (up from 21 to 25).

Original articles still averaged 15 pages per issue, and the nurses' section 8.

The financial picture is still a credit to Mrs. Bennett's judicious management. Herewith, the figures for the past 3 years:

	1952-53	1953-54	1954-55
Income			
Gross advertising receipts	$11,300	$13,600	$15,015
Subscriptions and sales	2,200	2,600	2,527
Total income	$13,500	$16,200	$17,542
Expenses			
Commissions and discounts	$ 1,700	$ 2,300	$ 2,479
Printing and postage	10,000	11,300	12,426
Total expense	$11,700	$13,600	$14,905
Net profit for the year	$ 1,800	$ 2,600	$ 2,637

Our circulation is as follows:

Paid subscriptions	
Doctors	505
Nurses	628
Other	154
Exchanges	188
Miscellaneous	188
TOTAL	1,663

Mrs. Robert Katsuki and her assistants from the Woman's Auxiliary have made an outstanding contribution to the Medical Association by preparing an extensive collection of biographical sketches of Island doctors from the earliest days. It is the recommendation of our Advisory Board that this material be published serially in our JOURNAL in connection with our Centennial celebration.

We are also requesting the assistance of Auxiliary members in the compilation of a fifteen year cumulative index of the JOURNAL, with a view to publishing it in our Centennial year.

The Board recommends that its name be changed from Advisory Board to Editorial Board.

The JOURNAL would be more fun to edit and publish, more interesting to read, more attractive to advertisers, and therefore more profitable, if it operated in less of a vacuum. We get the impression that if blank copies were mailed instead of printed ones, no one would notice it but the advertisers. This is a pretty good JOURNAL, as state journals go. We think it's worth your time to read it, and we'd like to hear some criticisms occasionally, or some constructive suggestions, or some compliments. And we recommend the JOURNAL'S continued publication on the same basis as heretofore.

REPORT OF THE HEALTH EDUCATION COMMITTEE

Katherine J. Edgar, M.D., Chairman

During the past year, the Health Education Committee of the Hawaii Medical Association has devoted almost exclusive time to half-hour monthly TV programs on KONA-TV. The following programs and participants were scheduled on public service time:

May	Cancer: Drs. W. Harold Civin, R. D. Moore, Grover H. Batten and Herbert Chinn
June	Heart Disease: Drs. N. P. Larsen, Homer Izumi, Fred I. Gilbert
August	Physical Examinations: Drs. Elmer Johnson, Duke Cho Choy and Katherine Edgar
September	Allergy: Drs. Archie Chun-Ming, Clarence Sugihara and Tell Nelson
October	Skin: Drs. Samuel D. Allison, H. M. Johnson and Wilfred Kurashige
November	Diabetes: Drs. Morton E. Berk, L. T. Chun and Cecil Saunders
January	Pregnancy: Drs. S. Nishijima, K. S. Fong and C. C. McCorriston
February	Delivery (Birth of a Baby): Drs. Lyle Bachman, E. F. Cushnie and Thomas Y. K. Chang
March	Medicine as a Career: Drs. Harry L. Arnold, Jr., James H. Albright (resident, Queen's Hospital), George Nagao (University of Hawaii premedical student) and Wallace Fukunaga (McKinley student)

In the course of this last program we discovered that the premed students at the University felt the need for

advice from practicing physicians and we are now trying to work out a plan to meet this need.

An editorial summarizing the year's activities appeared in the March-April HAWAII MEDICAL JOURNAL.

The Committee has been discussing possible sponsorship for a regular program with KONA-TV manager, Mr. Jack Chandler. (One sponsor is considering concrete plans at present. Until we know their decision financial plans are indecisive.)

Mr. Fred Briggs of KONA-TV has offered the Medical Association 10 minutes weekly for an interview type of program at about 2 p.m. on any subject of medical interest to "homemakers." The answer to this offer will be decided when we know about sponsorship for the monthly program. Publicity and visual aids, so necessary to successful TV programs, must have financial support.

REPORT OF THE MEDICAL PLAN COMMITTEE

Walter B. Quisenberry, M.D., Chairman

The Medical Plan Committee was appointed in accord with action taken by the House of Delegates on Sunday, February 6, 1955. The motion which was passed creating the committee reads as follows:

A motion was passed that a committee be appointed to explore the situation for the total Medical Association to get a clearer view of the proposals made by Dr. Garfield and Mr. Kaiser. The committee will seriously consider the type of plan Dr. Garfield has recommended as a possibility within the boundaries of the Hawaii Medical Association. The committee shall be representative of group and individual practice and shall be interracial. This committee shall recommend whether or not such a plan should be established in the Territory, by our Association or by a group outside our Association. Such study shall also consider the inclusion of preventive services. The committee was also authorized to call on anybody for discussion, without restriction. It will report its findings to the House of Delegates.

After the meeting on the above date, the President appointed the following committee members:

Walter B. Quisenberry, M.D. (Chairman)	John M. Felix, M.D.
T. H. Richert, M.D.	John J. Lowrey, M.D.
Frederick L. Giles, M.D.	Shoyei Yamauchi, M.D.
Edmund Ing, M.D.	Samuel L. Yee, M.D.
William S. Ito, M.D.	Dorian Paskowitz, M.D.
L. A. R. Gaspar, M.D.	Andrew L. Morgan, M.D.
	Duke Cho Choy, M.D.

At its first meeting the committee discussed its method of procedure, particularly in view of the motion passed at the Honolulu Society's special meeting regarding contract panel medicine. It was agreed that the committee would investigate various plans and report the facts to the House of Delegates.

Following this method of procedure, the chairman invited Mr. Veltmann and Mr. Yuen of H.M.S.A. to meet with the committee. They have now discussed with the committee the new Community Medical Plan, how it may offer all the advantages and none of the disadvantages of panel medicine and how it might be improved.

After completing the meetings with Mr. Veltmann and Mr. Yuen, Dr. Rodney West, chairman of the Medical Committee of H.M.S.A., also met with the Committee and presented information contained in letters from various labor leaders regarding the community medical plan.

Further meetings are planned where information will be presented on what Medical Associations on the mainland have done in developing community medical plans which will contain all the advantages and none of the disadvantages of a panel system. Consideration will be given to the proposals made by Dr. Garfield and Mr. Kaiser. The committee will also secure information on the operation of the Kaiser plan in other communities.

The committee is seeking opinions from the Hawaii, Kauai and Maui Societies regarding the action of the Honolulu Society on contract panel medicine.

The work of the committee has thus far been investigative, so no recommendations can be made at this time.

REPORT OF THE EMERGENCY MEDICAL SERVICE COMMITTEE

Robert B. Faus, M.D., Chairman

The Territorial Committee on Emergency Medical Service and Advisory Committee to Selective Service for special registrants has been continuously active throughout the year. Since our last annual report 14 doctors have entered the service:

CAPT. FRANCIS AU	CAPT. RICHARD S. F. LAM
LT. (JG) ROBERT F. BOUDREAU	1ST LT. BUNZO NAKAGAWA
CAPT. ROBERT M. BROWNE	1ST LT. THOMAS K. OSHIRO
1ST LT. ALFRED Y. T. CHING	1ST LT. HERBERT G. PANG
LT. KENNETH E. HO	LT. (JG) EDWIN A. ROTHROCK
CAPT. FREDERICK M. K. LAM	LT. DUANE E. TRUESDELL
LT. PRITCHARD R. C. LAM	LT. (JG) JACK S. WOODRUFF

The following 25 doctors have completed their service and returned to civilian life.

EDWIN R. BALLARD	ROBERT K. MOOKINI, JR.
GORDON Y. H. CHANG	NOBUYUKI NAKASONE
OLAF CHRISTOFFERSON	ROY R. OHTANI
SYDNEY T. FUJITA	KENNETH H. RUSCH
WILLIAM H. GULLEDGE	SHIGEO SHINKAWA
ROBERT P. JAY	H. JOSEPH SIMON
KEITH F. O. KUHLMAN	WALTER S. STRODE
KIKUO KURAMOTO	I. SAM TASHIMA
CYRUS W. LOO	JUN-CH'UAN WANG
SAMUEL C. Y. LUI	R. P. WIPPERMAN
CHEW MUNG LUM	FRANCIS K. L. WON
EDMUND C. K. LUM	STANLEY S. K. WONG
EDWARD C. WO LUM	

We salute them for completing a service well done.

Of 354 active members of the Honolulu County Medical Society, 122 have served in the armed forces since December 7, 1941.

The entire Advisory Committee participated in Civil Defense exercise "EVERSHARP 6," "EVERSHARP 7" and a continuation of "6."

By invitation the entire Committee visited the Diamond Head storage area for medical supplies which include aid station and hospital equipment, medical and surgical supplies, whole blood, plasma and plasma expander. Two mobile hospital units are on order.

Budgets have been presented to this legislative session for health services amounting to $15,000 in Federal matched funds and $67,561 in Territorial funds. At this time it is still uncertain how much will be appropriated by the legislature.

Governor King has been especially interested in Civil Defense matters and recently called a meeting of his advisory council and all department heads of the Territory. At that time they were briefed on the operations of Civil Defense and it was made incumbent on them to plan the use of all employed personnel of the Territory for assigned Civil Defense duties. A training program for wardens has been set up and will be carried out for selected territorial employees. They in turn will train additional wardens. Thus a much larger number of people with assigned duties will be available in the event of an emergency.

Mrs. Bennett, our secretary, has been most careful in orderly processing of records for physicians and keeping the doctors advised as to their status and vulnerability. The Keysort file system which is now being completed will be an invaluable help in the processing of physicians.

REPORT OF THE LEGISLATIVE COMMITTEE

Theodore T. Tomita, M.D., Chairman

I am sure that every physician in the Territory has followed the newspapers carefully and already is aware of the happenings in the present legislature. The Legislative Committee discussed all the important bills that were being introduced and tried their utmost to have bills passed that were favorable to the entire society. The most controversial bill was House Bill 151 regarding free choice of physician in cases of industrial accidents. I say controversial because the Insurance Carriers, the Employers Council and the Sugar Companies opposed this bill because they felt that the cost of medical care would be increased. They also felt that the present voluntary system which was instituted in August of 1954 was working well. This committee felt that we were in complete accord with the principle of free choice of physician, but were opposed to this bill because it would have given the employer and employee, after collective bargaining, the right to *hire* their own physician. We pointed out to the law makers that this section of the bill contradicted the entire aim of free choice and eventually had this section deleted on the floor. The Senate deleted a minor section of the bill and the Governor has signed this bill into law.

At the present time fluoridation has passed the House, but as yet Senator Duarte is filibustering against this bill. However, we are confident that if this bill is put to vote it will pass the Senate. [It did, but was pocket vetoed by Governor King.—Editor]

House Bill 716 was another controversial bill as far as the committee was concerned. This bill, if passed, would exclude all physicians as expert witnesses when testifying as to insanity except psychiatrists who are Board members. This committee was opposed to any special legislation for one group of specialists and therefore it was referred to the Board of Governors for their opinion and advice. The Board of Governors also opposed this bill, but at the present time it has not come up for hearing.

House Bill 662 is a bill raising the residence requirement from 1 year to 3 years before a physician is eligible to take the board examination for licensure. This committee felt that 1 year was sufficient, but since the bill had been introduced at the request of a few physicians, this bill was also referred to the Board of Governors for their disposition. This bill was brought out at a general meeting for general discussion and the consensus was the present 1 year was sufficient. This bill also has not been reported out as yet.

Special Bill 493 is a bill, introduced by Senator Duarte of Maui, which is a form of socialized medicine where 2% taxes were to be collected to furnish free medical services. This bill died in one committee.

The Legislative Committee endorsed many bills pertaining to the Board of Health such as a new building, new x-ray equipment, funds for rehabilitation, rheumatic fever, etc. Whether we have done any good is rather questionable, because of the tight budget the legislature has had to work with.

I do not have any special recommendations except to say that all doctors must take a more active part in community affairs including politics.

In closing I would like to thank Mr. Kennedy for collecting and sorting all the bills that were introduced and keeping me informed. I must also thank the members of my committee, Doctors Lee, Henry, Freeman, Fukushima, Choy, Richardson and Felix, for the wonderful support and advice they have given me during this session.

REPORT OF THE POST GRADUATE COMMITTEE

Morton E. Berk, M.D., Chairman

During the fiscal year, we have been fortunate in hearing men of national repute. During March, Dr. Lauren Ackerman, Professor of Pathology at Washington University, gave a series of lectures on the various aspects of cancer. His appearance was financed by the Hawaii Cancer Society.

For the post graduate lectures sponsored by the Honolulu County Medical Society and then by each of the other county components, we have Dr. William Kirby, Professor of Medicine at the University of Washington in Seattle, who will speak on chemotherapy, antibiotics and infectious medicine.

For 1956, the year of the centennial celebration of the Hawaii Medical Association, your committee recommends bringing down two men. A team such as Dr. Gross, a well-known surgeon in Boston, and Dr. Edward Neuhauser, a well-known roentgenologist also from Boston, should be of real value to our medical community. They will be able to work closely together in preparing the series of lectures to be given at that time.

REPORT OF THE PROFESSIONAL SERVICES COMMITTEE

F. L. Giles, M.D., Chairman

After approximately seven months of hard work, during which time we met with representatives of insurance carriers, representatives of the Employers Council, representatives of labor unions, various members of the profession, private individuals, and representatives of the HMSA, our committee developed, I believe, an outstanding prepaid medical plan, a plan which is meant to serve the people of Hawaii in a capacity which no other prepaid plans have yet been able to do. This plan has been submitted to the HMSA and to the Medical Society for their acceptance. During the work in developing this plan, many new ideas and much new information were brought to light concerning the medical services in Honolulu. During the past few months, from various lay organizations much pressure has been brought against the medical profession to set up a median or average fee schedule. This pressure has particularly come from the ILWU and the United States Life Insurance Company. Their reasons appear to be an "overcharging" in some instances, and as far as our information is concerned, these instances are of a questionable nature and probably are the result of misunderstanding between the parties concerned. It would appear to us, from the information which we have gained, that the insurance companies themselves are paying fees which are under the regular standard fees in the community in many instances. This question comes up in the preparation of the prepaid plan, particularly as far as income levels are concerned. Long periods of debate in our committee took place over the question of setting the income level at which payment in full was to be the going rule, according to the fee schedule of the HMSA or other insurance companies.

Generally, it appeared that in working with HMSA the labor organizations in the community somewhat resented the fact that they had not been included on the

Board of Directors of HMSA. Such inclusion would appear to be advantageous to the HMSA and the community at this time.

An important factor in the cost of medical care, which has been ignored or bypassed in the community, is the cost of hospitalization. The profession itself has taken the brunt of the blame of the high cost of medical care from the carriers and individuals of the high cost of hospitalization. The doctors have taken less in fees, because of the high cost of hospitalization. The doctors have been swamped by the propaganda of the cost of medical care and have hesitated to derive fair payment for the services which they have rendered. The hospitals have not hesitated to derive more than their share from the cost of medical care. The hospitals have at no time hesitated to raise their rates as the cost of maintenance has increased. In many instances the hospitals here have raised their rates unnecessarily without due regard to improving the efficiency of their services and adjusting their business affairs to the changing times. As you know, our committee has attempted to suggest to the hospitals ways and means by which some of these costs could be decreased. We have received no cooperation from any of them. It is possible that a survey by an outside economist might prove to be more valuable, and with the help of the Public Health Committee of the Chamber of Commerce, might be able to produce enough pressure on the hospitals to get them to accept the recommendations of such an individual. This is a point which must be explored.

Lastly, the most important contribution that the doctors have to offer today in any kind of prepaid medical plan, which is to combat the so-called Kaiser plan, is the fact that the patient has free choice of physician under the plans we are developing. Regardless of the propaganda which the Kaiser people are trying to put over, the patients under the Kaiser plan do not have free choice of physician. We must continue to put before the public the benefits which are derived from such a system as ours.

As of May 4, 1955 the Community Health Plan has been accepted and approved by all the County Medical Societies in the Territory, including the fee schedules. The plan is now ready to be submitted to interested groups for their participation. The HMSA has been selected as the underwriter for this Community Health Plan. The promotion of the plan and the contacts with various groups will be carried out through HMSA.

REPORT OF THE PUBLIC SERVICE COMMITTEE

Sylvia Haven, M.D., Chairman

The present members of the Public Service Committee were appointed in May 1954. Five meetings were held. The Committee has accomplished the following:

(1) Two years ago, under the direction of Mrs. Peter Washko who was then the Woman's Auxiliary member appointed to meet with the Public Service Committee, a project was started, with the cooperation of the Hawaiian Telephone Company, to form a Telephone Institute for doctors' secretaries. Mrs. Douglas Bell, the Woman's Auxiliary representative for this year, successfully completed this project and the lectures were given in August 1954.

(2) The advertisement appearing in the yellow pages of the telephone book was rewritten in order to correct a previous ambiguity.

The advertisement of the Honolulu County Medical Society on the inside cover which is given to us free as a public service, appears in the lower left corner instead of the right upper corner of the page. This is a more noticeable location.

(3) An exchange of letters with the Telephone Company regarding the listings of the doctors under specialty headings finally assumed proportions outside the province of the Public Service Committee. This matter was referred to the Medical Practice Committee and then to the Board of Governors. Eventually, the Honolulu County Medical Society, as a whole, voted on this question and decided each doctor's name should be listed only under one specialty in the yellow pages.

(4) It is the current project to obtain the cooperation of all theatres and public places to have them page doctors by their "call" numbers and not by their names.

The Public Service Committee recommends the following for consideration by the next year's Public Service Committee:

(1) Continue with the present project to page doctors by "call" numbers.

(2) Continue the custom of the Press-Radio-TV Dinner.

(3) It might be time saving, money saving and more direct to educate the representatives to the Legislature towards the doctor's attitude than to lobby against these men later. An annual dinner on the order of the Press-Radio dinner might be considered.

(4) A request has been made for an annual contribution by the City and County to our medical library as a token of appreciation for the work the doctors do, without charge, for staff patients.

It was suggested at a recent meeting that a statistical survey showing the number of patients treated and number of doctor hours spent could be used advantageously. This is suggested as a possible project for the next Public Service Committee.

REPORT OF THE WOMAN'S AUXILIARY TO THE HAWAII MEDICAL ASSOCIATION

Mrs. Ralph B. Cloward, President

During the fiscal year 1954-55, the Woman's Auxiliary to the Hawaii Medical Association assisted the doctors by providing hospitality and interesting social programs for seven medical conferences held here. These were: the New Orleans Graduate Assembly, the American Academy of Pediatrics, the Pacific Coast Oto-Ophthalmological Society, the Post A.M.A. Convention, the Pan-Pacific Surgical Congress, the Academy of General Practice Post Convention and the annual Territorial Meeting.

Several extraordinary features, such as the hostess–information desks maintained at the Royal Hawaiian Hotel, international fashion shows, pageants, luaus, and Chinese dinners, beside the usual luncheons, receptions and cocktail parties, contributed to the success of the meetings as well as upholding our reputation for "Hawaiian Hospitality." Beautiful flowers and leaves were brought from members' own gardens for the many decorating projects.

In an effort to achieve closer coordination between the Territorial Auxiliary and the county groups, the President attended both Maui and Hawaii Counties' annual meetings, at which time possible projects were discussed. For the same reason, minutes of each meeting have been exchanged among the counties. Honolulu County is putting out a News Letter prior to each meeting which is sent to all doctors' wives on Oahu as a device to increase its membership. This year too, a page in the HAWAII MEDICAL JOURNAL devoted to the Auxiliary activities has been written by Mrs. Louis Buzaid and Mrs. Joseph Lam. The Auxiliary is completing the biographical sketches of island doctors from the early days to more recent times. Freshly cut flowers are arranged weekly at the Hilo Memorial Hospital by Hawaii members. Two dinner meetings were held in the name of the Maui Auxiliary for visiting doctors.

Delegates to the annual meeting of the Woman's Auxiliary of the A.M.A. in San Francisco last June were Mrs. Frank Spencer and Mrs. Robert Bailey, who presented leis to the national officers from the Hawaii Auxiliary.

Revisions in the Constitution and By-Laws which would correspond with the changes in the Woman's Auxiliary to the A.M.A. were prepared and are to be submitted to the House of Delegates to be voted upon at the May meeting.

We have a total membership of 235, made up of 25 from Maui County, 28 from Hawaii County, 177 from Honolulu County and five members-at-large from Kauai. Honolulu had an increase of 14 members and Maui an increase of 3.

ADVISORY COMMITTEES

REPORT OF THE ADVISORY COMMITTEE TO THE BUREAU OF CRIPPLED CHILDREN

Ivar J. Larsen, M.D., Chairman

The annual meeting of the Advisory Committee to the Bureau of Crippled Children was held on January 17, 1955. The following points were discussed and recommendations made:

1. *Hearing Conservation Program*—The results of this program carried out during the past year have indicated that the school program of otologic clinics had been very well received in the areas where it had been conducted, and that the number of children reporting to their private physicians for treatment of conditions discovered during these otologic clinics, had increased to about 82% as compared to less than 50% of children previously examined and found to have hearing loss.

The Advisory Committee voted unanimously that it was in favor of increasing the scope of the conservation of hearing program as rapidly as possible, particularly into areas where the program had not been put into effect, and that the program should include medical services where they are not available.

2. *Mentally Retarded Program*—It is obvious that increasing pressure groups in the communities are stimulating interest generally in mentally retarded programs to the point where substantial funds are to be sought in the coming legislative session for training facilities and training centers for the mentally retarded child. It was the feeling of the Committee that, should appropriations be made for such a program, the best utilization of such funds would be obtained only by having adequate medical evaluation for all patients being considered for admission to any training center which might be established by a government agency. With this in view, the Committee recommended to the Legislative Committee of the Medical Association and to each County Medical Society, the adoption of a complete medical evaluation for all patients being considered for admission to a training center which might be established by a government agency; and further, that such an evaluation program be under the administrative control of the Bureau of Crippled Children. It was further recommended that programs at government expense for trainable children should be begun on a pilot or trial basis only until such time as an evaluation of the program can be made.

3. *Appropriations for Cerebral Palsy and Rheumatic Fever*—The appropriations for cerebral palsy and rheumatic fever from the Federal Government are due to be discontinued, the latter having been already eliminated from the Federal Budget. It was felt by the Committee that these types of preventive programs are important to continue. Dr. Connor was asked to submit information on the Rheumatic Fever Program to Dr. Lowrey to be submitted to the Legislative Committee for consideration when the budget comes before the house.

4. *Research and Resource Committee*—At the request of the Research and Resource Committee, consideration of examinations and re-evaluations of children with physical handicaps who are given special services in public schools, and especially those with hearing losses and organic speech defects, was discussed. The Committee had unanimously recommended the following: A medical committee be appointed which would—1. Review the medical data on all children being considered for admission for special training in a public school because of a hearing loss or an organic speech disorder, and re-evaluate all such cases on a yearly hasis. 2. Confer with the referring doctors if more medical information is needed.

The Committee recommends that a Medical Evaluation Committee be composed of:

1. An otologist appointed by the Otolaryngology Society.
2. A pediatrician or general practitioner appointed by the Pediatric Society or General Practice Society or the local Medical Society.
3. A D.P.I. audiometrist or speech therapist.
4. An educator selected by the D.P.I.
5. A speech and hearing specialist of the Bureau of Crippled Children, and, further, that insofar as possible, speech reception tests be given to those children with hearing losses being considered for special training.

REPORT OF THE ADVISORY COMMITTEE ON DAY CARE CENTERS TO THE BOARD OF HEALTH

Duke Cho Choy, M.D., Chairman

The following is the annual report of the Advisory Committee on Day Care Centers to the Board of Health. A committee consisting of Dr. Gilbert Halpern and myself met once with Dr. Katherine Edgar of the Bureau of Maternal and Child Health of the Board of Health. The problem presented concerned an advertisement of a day care center which appeared in the HAWAII MEDICAL JOURNAL. Reliable reports attested to the fact that the physical set up and regulations of the center in question were not meeting acceptable standards. The committee decided that the advertisement should be dropped from our JOURNAL in as much as its continuance might be interpreted as sanction of the day care center by the Hawaii Medical Association. The committee was aware that groups concerned with day care centers in our community were actively at work in legislation to be introduced in the 1955 Legislature, to allow the Board of Health to set up regulations which such centers must meet.

We recommend that the committee be maintained next year.

REPORT OF THE ADVISORY COMMITTEE TO THE BUREAU OF MATERNAL AND CHILD HEALTH

K. S. Tom, M.D., Chairman

A total of four meetings were held during the past year. Three meetings were devoted exclusively to the study of maternal deaths occurring in the Territory. The remaining meeting was used to discuss general problems relating to maternal and child health.

Following the policy of the previous year, the three meetings devoted to the study of maternal mortality were held on Kauai, Hawaii and Oahu. Eleven maternal deaths were studied and they were as follows:

Sepsis	3
Hemorrhage	2
Eclampsia	1
Cerebral Hemorrhage	1
Heart Disease	1
Carcinoma of Breast	1
Air Embolism	1
Accidental Injection of Sedatives	1

Eight of these cases were thought to be preventable, two non-preventable, and one was not decided due to lack of information.

The annual meeting was held in Honolulu on January 17, 1955. Some of the problems studied and their conclusions were as follows:

Pamphlets on Body Mechanics—One copy of the pamphlet on body mechanics should be sent to all doctors in the Territory who care for obstetrical patients, informing them that such pamphlets are available for their patients. After one year the number of such pamphlets requested by doctors should be determined, and the question of charging for them should be considered.

Proposed Short Outline for Prenatal Care—The question of the Bureau of Maternal and Child Health's preparing a short outline for prenatal care was discussed. It was felt that the subject should be dismissed.

**List of Obstetrical and Pediatric Consultants*—A list of consultants in Obstetrics and Pediatrics should be kept by the Bureau of Maternal and Child Health but should not be circulated to the hospitals and doctors.

Proposed Fetal and Birth Certificates—This subject was discussed in detail with Mr. Charles Bennett, Chief of the Bureau of Health Statistics of the Department of Health. The committee suggested that prenatal blood test items be put back on the fetal death certificate and the date of the LMP on certificates be eliminated. The committee felt that the proposed live birth and fetal death certificates should be approved.

Responsibility of Bureau of Maternal and Child Health to a Pregnant Woman Not Under Medical Care—The committee felt that the public health nurse should use her own discretion in handling maternity patients not under medical care.

Availability of Blood in Hospitals—The committee makes strong recommendation to every hospital which admits maternity patients that low titre O blood should be stocked and always be available, and further that stocking of low titre O blood should be a Board of Health regulation for the licensure of hospitals caring for maternity patients.

* This paragraph was not approved by the House of Delegates.

REPORT OF THE ADVISORY COMMITTEE TO THE BUREAU OF TUBERCULOSIS

S. E. Doolittle, M.D., Chairman

This committee is dormant—dead. Not consulted, not contributing to the official TB program.

Recommend discontinuation.*

* Note from Executive Secretary: While agreeing that we should not maintain inactive committees, a check with the Bureau of Tuberculosis indicates that this committee was not called upon during the past year because there was no change in the program. However, such changes are anticipated in the coming year and the Bureau will need the advice of the Medical Association. It might therefore be wise to appoint such a committee again.

REPORT OF THE ADVISORY COMMITTEE TO THE BUREAU OF VENEREAL DISEASES

Harold M. Johnson, M.D., Chairman

Dr. Samuel Allison, of the Board of Health, reviewed the administrative setup of the Bureau of Venereal Diseases at the Department of Health and attempted to show the size of the VD budget and the relationship within the bureau of venereal disease activities to other activities such as cancer and heart. He then discussed the activities of the venereal disease clinic at Kapahulu which, at the present time, is manned by part-time physicians. He presented the statistical picture of this clinic for the year 1953 indicating that the average daily visits were approximately 23 and that of approximately 9 new patients seen per day, 6 were prediagnostic cases largely representing contacts of venereal disease. He reviewed his confernces with various staff members of the bureau and the belief that too many old cases are being held onto, the "insurance treatment" of certain cases, etc.

Recommendations were made and approved that the bureau rapidly clear its files of adequately examined and treated cases; that the major responsibility for evaluating these cases would be by the clinic physicians who have now been in this field of activities for over a decade; that questionable cases would be referred to the acting bureau chief; and that "insurance treatment" of syphilis cases in general should be stopped.

The management of gonorrhea and contacts of gonorrhea was discussed. At the present time, no contacts or cases are treated until a positive diagnosis is made. It was recommended that promiscuous contacts of gonorrhea cases be given prophylactic treatment consisting of 600,000 units of a long acting penicillin preparation as, for example, bicillin. There was discussion as to whether this could be done and the feeling was that this type of preventive treatment could be urged upon the contacts. These prophylactically treated individuals should be followed subsequently as if they were actually treated cases of gonorrhea. The follow-up procedure recommended was that expressed on page 2 of Public Health Service Publication 327.

The chancroid picture was discussed and the difficulties of management of contacts of chancroid reviewed. The committee recommended that within the judgment of the examining physician, female contacts of chancroid be treated as if they did have chancroid. The treatment schedule to be followed being that indicated on page 11 of the above Public Health Service Publication 327. The committee also pointed out the need for careful management of such patients and the need for forcing fluids and watching the urine picture in these individuals.

Dr. Max Levine presented a number of laboratory problems. The committee is aware of the problem of physician education concerning management of fixed positive blood tests. The committee approved Dr. Levine's request to change the reporting of blood tests from that of positive, doubtful and negative to reactive, weakly reactive, and nonreactive. Dr. Levine is to prepare a memorandum to physicians concerning this change in reporting procedure and after a transitional period to effect this change.

There was a brief discussion as to the recent increase in gonorrhea and the existence of a number of women in the community who have now been contacts of known cases of chancroid. The Department of Health was asked to inform the physicians of the community as to the increase in gonorrhea and the need for awareness in relationship to chancroid. It was also suggested that the Department of Health might send out the above recommended treatment schedules to the physicians.

NO REPORT

The following committees have held no meetings during the year, nor have they been called upon for advice:

Chronic Illness Committee
Heart Advisory Committee
Industrial Relations Committee
Radium Advisory Committee
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Dramatic Remission of Ulcer Pain

Pain of ulcer is associated with hypermotility; the pain is relieved when abnormal motility is controlled by Pro-Banthīne.

"In studying[1] the mechanism of ulcer pain, it is obvious that there are at least two factors which must be considered: namely, hydrochloric acid and motility.

"... our studies indicate that ulcer pain in the uncomplicated case is invariably associated with abnormal motility....

"Prompt relief of ulcer pain by ganglionic blocking agents ... coincided exactly with cessation of abnormal motility and relaxation of the stomach."

Pro-Banthīne Bromide (β-diisopropylaminoethyl xanthene-9-carboxylate methobromide, brand of propantheline bromide) is a new, improved, well tolerated anticholinergic agent which consistently reduces hypermotility of the stomach and intestinal tract. In peptic ulcer therapy[2] Pro-Banthīne has brought about dramatic remissions, based on roentgenologic evidence. Concurrently there is a reduction of pain, or in many instances, the pain and discomfort disappear early in the program of therapy.

One of the typical cases cited by the authors[2] is that of a male patient who refused surgery despite the presence of a huge crater in the duodenal bulb.

"This ulcer crater was unusually large, yet on 30 mg. doses of Pro-Banthīne [q.i.d.] his symptoms were relieved in 48 hours and a most dramatic diminution in the size of the crater was evident within 12 days."

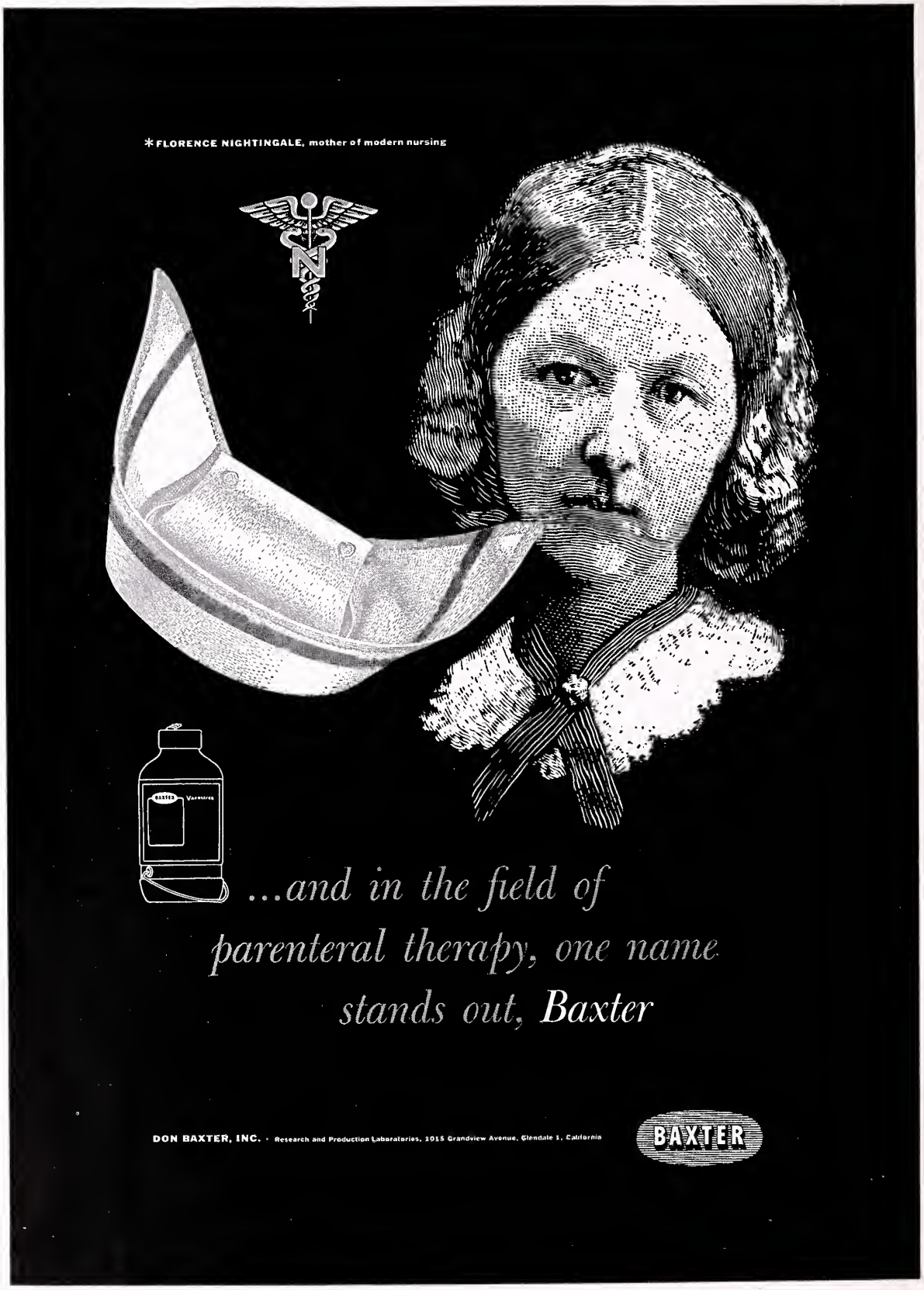
Pro-Banthīne is proving equally effective in the relief of hypermotility of the large and small bowel, certain forms of pylorospasm, pancreatitis and ureteral and bladder spasm. G. D. Searle & Co., Research in the Service of Medicine.

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1. Ruffin, J. M.; Baylin, G. J.; Legerton, C. W., Jr., and Texter, E. C., Jr.: Mechanism of Pain in Peptic Ulcer, Gastroenterology *23*:252 (Feb.) 1953.

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INTER-ISLAND NURSES' BULLETIN

Official Publication of the Nurses' Association, Territory of Hawaii

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PRESIDENT'S MESSAGE

The generous response of the nurses of Hawaii to the appeal of the Board of Health for assistance with the poliomyelitis vaccine program is evidence of their willingness to contribute time and energy to projects designed to safeguard the welfare of our community. Deep down in the heart of every nurse is a sincere desire to help others. However, good-will alone is not sufficient. Nurses must be prepared to meet intelligently any disaster that threatens the well-being of our people.

Should a major catastrophe strike our Islands at the present time, it is doubtful that the majority of nurses would be adequately prepared to meet it. Many of us are concerned about our deficient knowledge in regard to atomic nursing. The American Nurses' Association and the National League for Nursing are urging us to make every effort to prepare for disaster nursing but we are somewhat confused as to just how we should go about it. The League offers an excellent pamphlet entitled *Nursing During Disaster, A Guide for Instructors in Basic Professional Programs and Practical Nurse Programs,* 1951 along with a recent supplement to help us plan for current students. These multilith copies are available from the National League for Nursing, 2 Park Avenue, New York City at $1.25. Hospitals and local Nurses' Associations also might find these publications useful as a starting point for in-service or association programs on disaster nursing for nurses who graduated from schools of nursing before such material was integrated into basic curricula.

Since nurses are also members of families, it would seem to be in order for them to take the leadership in learning more about, and disseminating information found in, the many well-written official civil defense publications such as "Home Protection Exercises" which is available from the United States Printing Office in Washington, D. C. at twenty cents each or from the Honolulu Armory, Department of Civil Defense, free of charge. Keeping up with current literature in the *American Journal of Nursing and Nursing Outlook* is another effective method of increasing the knowledge that will prove so necessary in case of a national disaster. Such articles as the "Procedure Breakdown as a Teaching Tool" found in the April 1955 issue of *Nursing Outlook* on page 199 should be read by every professional nurse regardless of her position in nursing.

Undoubtedly the American Nurses' Association will provide us with additional leadership in the perplexing problem we face of assuming our share of the responsibility of planning for civil defense but the real work will have to be done on state and local levels . . . by all of us working together and making the best use of the different talents God has given us.

SISTER MARY ALBERT, R.N., O. S. F.

THE FUNCTION OF A PROFESSIONAL ORGANIZATION

DR. WAYNE McMILLEN, CARNEGIE VISITING PROFESSOR UNIVERSITY OF HAWAII

It is a wholesome thing for any organization to re-appraise its objectives occasionally. At this meeting the Nurses' Association, District of Oahu, is instituting such a re-appraisal. The values resulting from this undertaking will depend upon the extent to which the members participate in the

thinking and the discussion by means of which self-evaluation proceeds.

The thing we must bear constantly in mind about any professional person is that his or her primary concern must be the rendering of skilled service to those who need it. Let me say this in another way: The professional person who has a truly professional outlook cannot place his own desires or his own welfare ahead of his professional obligations. We find this doctrine clearly set forth in the oath of Hippocrates to which doctors subscribe. We find that the professional organizations of lawyers impose upon attorneys the obligation to put the attaining of justice ahead of all other considerations. I am not saying that all doctors, all nurses, all lawyers, all social workers always behave in conformity with this professional obligation. Ideals are goals we strive for—and we must have them even though we fall short of attaining them.

The hierarchy of objectives is one of the attributes that distinguishes a professional organization from a trade union. A trade union necessarily and rightly places its emphasis upon getting better pay and better working conditions for its members. Professional organizations likewise seek better pay and better working conditions for their members, but this objective is not the *primary* purpose of the professional association. Professional groups seek better pay and better working conditions because they know that this is one means of attracting promising people into the profession and keeping them there. In other words, better conditions of employment are one means to an end in a professional organization, whereas in a union better working conditions are in themselves the major end sought. An evidence of this distinction between professional organizations and unions is that, in general, professional organizations do not resort to the strike as a means of gaining their objectives.

A major purpose of any professional organization is to raise the standards of practice. Every one of the professions has tried to restrict practice to those who are properly qualified to engage in practice. Some professions have been able to obtain legislation in every state that excludes from practice all those who cannot meet certain qualifications. In the legal profession this is achieved by imposing a series of examinations. A licensing system of this type has been in effect so long in law and medicine that we sometimes forget how hard they struggled to develop it. Years ago I knew an M.D. who was the Governor of Arizona. Fifty years earlier he had graduated from a two-year medical course offered by a struggling college now long since defunct. Even then many of the states already had licensing provisions that made it impossible for him to practice within their borders. But he was able to get a license in Arizona. He practiced there for 50 years, delivered thousands of babies, and waited until they grew up. Then he ran for Governor, and they elected him.

We forget, too, that some of the professions have still a long way to go in restricting practice to those really qualified to render the needed service. For example, architects have succeeded in some states in limiting practice to qualified people; in other states they have made little or no headway. Librarians are another group that is still struggling with this problem and seeking ways to insure that library service will be in the hands of those trained for library work.

In social work an enormous job remains to be done. There are roughly 125,000 people holding social work jobs. Of this number not more than 30,000 are qualified by professional education to perform social work functions. A start has been made in a very few states to set up official systems of registration. Registration, of course, does not exclude unqualified persons from practice, but it is a step in that direction. Moreover it tends to raise the quality of practice because it stimulates the unqualified to seek the education and experience required of those who wish to practice as registered workers. At the present time, it would be futile to seek a licensing system that would exclude from social work or from nursing practice all who are not licensed. The reason is apparent—there are not enough practitioners who could obtain licenses to fill the jobs that must be filled. The nursing profession has made remarkable progress in extending registration, but because of the shortage of registered nurses, a considerable volume of nursing care continues to be provided by so-called "practical" nurses who do not have full qualifications.

The differing rates of progress made by various occupational groups that are seeking to protect the public by restricting practice to those qualified have led to some ironical situations. In Illinois, for example, a woman cannot get a license to practice beauty culture without taking a prescribed course and then passing state examinations. As a result a customer who wants to have her hair curled can be fairly sure the operator knows the machines and won't burn her scalp. But if the same woman needs advice about her pre-delinquent daughter, there is no assurance that the social worker she consults at the juvenile court will know even as much as she does about deviant behavior in adolescents.

I don't want to leave the impression that the only way a professional organization can protect and raise standards is to obtain official registration or official licensing. I am really trying to make three points: first, that a primary responsibility of any professional organization is to protect standards of practice and to raise them; second, that registration is an illustration of one way in which professional organizations advance toward this objective; third, that a licensing system which makes it illegal for the partially qualified to practice may be a desirable ultimate goal but, owing to the shortage of nurses, is not at present a practicable immediate goal.

I cannot explore exhaustively all of the other ways in which a professional organization can protect and raise standards, but I can perhaps enumerate a few of them. First, the very existence of a professional organization tends to protect and raise standards. People cannot obtain membership in a professional organization without meeting some minimum defined standards of competence. Many people who cannot qualify for membership are thus stimulated to seek the additional education and experience required to attain membership. This has a leavening effect upon the field of practice. Second, the formulation and periodic revision of a good set of employment practices and the active promotion of these practices make the field more attractive and thus tend to retain good people in practice and to attract desirable recruits. Third, the formulation of standards of professional ethics and the implementation of these standards tend to increase respect for the profession. Among other ways in which standards are constructively influenced, we might mention: services rendered by members of the professional association in formulating job descriptions, submitting examination questions, acting as members of boards of oral examiners, and the like. All these activities have a positive influence on maintenance of standards.

Let us turn now to the function of a professional organization in recruitment. Every profession wishes to create a supply of qualified practitioners sufficiently large to handle the professional work that needs to be done. This problem has long been a major concern of the medical profession. I am sure you have heard of some of the studies made under the guidance of the medical profession that have showed what a serious under-supply of medical personnel exists in some parts of the country. A great deal has been said and done to remedy this situation. For one thing, funds have been made available to help finance the long, expensive education required in the medical field. In addition to these scholarship aids, very large sums have been obtained to help finance the medical schools.

The shortage of qualified professional nurses in this country has for at least a decade been a problem of major proportions. Last Christmas I was in a rural county in Iowa at the time of the death of an old friend who had practiced medicine there for 50 years. It was impossible to get a night nurse to care for this man in his last illness. Since he was unable even to ring for the floor nurse, the family called upon old friends to sit up with him at night. This service was gladly given, but, of course, it was not the professional nursing service the patient needed and deserved. It was a cause of distress to everyone that a man who had given his whole life to the care of the sick could not, in his own last illness, obtain the quality of care he deserved. The family was, of course, able and willing to employ a nurse, but no nurse could be found. So long as people in need of nursing care are unable to get it, this profession will continue to face a problem of recruitment. No one, of course, is interested in high-pressuring any young woman into the nursing field against her inclinations. But the plain truth is that many girls just finishing school know little or nothing about the opportunities available in a career of nursing. It is the job of the professional organization to see that as many of them as possible have the facts about the nursing profession placed before them when they are trying to plan their future career.

Your situation here in the Territory differs, I am told, from the situation throughout the rest of the country. Here you are fortunate in having more young women applying to schools of nursing than you are able to accept. I am sure you know the reverse is true on the mainland. But you are part of a profession, and, therefore, it is of concern to you that your profession is failing to attract an adequate number of recruits even though you yourselves may not suffer locally from this shortage. Moreover, even in this district, certain shortages exist—particularly in the area of teaching and administration. This means that even locally you need to give thought to the problem of persuading nurses to take the additional training required to qualify for these teaching and administrative positions in which the shortages exist.

Occasionally I have heard people say: "The trouble with our professional organization is that it's all talk and no action." Now, nobody who wants action should be squelched, because we need action, and plenty of it—provided it is realistic

action—and I'll say something further on that point later. But I want to take issue with those who object to talk. In any talk there is always some lost motion, of course. But in a professional organization, talk is not purposeless; most of it is directed toward an objective. Every profession, sooner or later, feels a need to develop a code of ethics. How could such a code be developed, if not by means of talk? Every profession starts out by saying that professional practice must be ethical. But what do we mean by "ethical"? This concept must be spelled out in detail before we can be sure we are abiding by it. And, of course, no profession can expel a practitioner from membership unless there is a written code of ethics. If there is such a code, the member has access to it and, therefore, cannot plead ignorance as an excuse for violating it. As you know, practitioners are occasionally expelled from the professional organizations, particularly from the medical and legal associations. Any profession may face a need to expel members as a means of curbing malpractice.

In any case, what I am trying to stress is the importance of talk. You do not have much except a vague idea unless and until you have a specific formulation—and a specific formulation results only from talk and discussion. The 40-hour week for nurses is an element in a statement of employment practices for nurses. This proposal was developed and has been successfully promoted by the ANA. However, a complete statement covering all aspects of employment practices remains still to be achieved. Until that is accomplished, the nursing profession is not in a position to say to an employer of nurses: "Here is a statement covering all the factors that constitute a desirable standard of employment practices for nurses." It is not easy to formulate such a statement. No one person can do it. Such a formulation results from widespread consultation and discussion — or in other words, from purposeful talk. However, I was happy to be told that this Territorial Association is in process of formulating minimum employment standards for nurses in industry, in public health, and for nursing administrators, and for general duty nurses.

Perhaps I have dwelt too long on this question of talk. All I am trying to say is that progress in the solution of any professional problem is dependent upon first achieving a clear formulation. Since formulations can be achieved only by discussion and agreement, I think we should respect purposeful talk and should recognize its direct bearing upon the advancement of the profession.

Many professional persons are also interested in action—and I am also very much interested in it. But experience has taught me that some kinds of action are helpful and other kinds are completely unproductive and may even be harmful. As a rule any profession finds it is not productive to try to "go it alone" in seeking needed legislation. The nursing profession in many jurisdictions, including this one, has been remarkably successful in obtaining needed legislation for the very reason that they have seen the importance of enlisting the interest and obtaining the support of other organized groups in the community.

Perhaps a concrete illustration will clarify this point. Illinois was one of the last states in the union to qualify for federal grants for Aid to Dependent Children. The reason was that our legislature refused to amend our existing mothers' pension law in ways that would qualify us to receive the federal funds. For quite a few years the social workers "went it alone" and lobbied directly in Springfield to obtain the necessary amendments. During this period the bill was never even reported out of committee. Then we changed our tactics. We looked around for a group that was numerically strong and influential and that might conceivably have some interest in child welfare. We discovered that both the American Legion and the American Legion Auxiliary had standing committees on child welfare. Neither organization was doing much about child welfare, but the fact that they had committees on child welfare showed that they thought they ought to be doing something about it.

It would be a long story to tell all the details of the approach to these organizations. Suffice it to say that an approach was made and that it led to continuing contact and collaboration on this one issue. The result was that the next time the bill came before the legislature, it was sponsored by the American Legion and the American Legion Auxiliary. Even then it did not pass the first time, though it did get out of committee. This initial rebuff really galvanized the Legion groups into action and at the next session, of course, the bill passed.

What I am trying to say is this: I believe in action, but I want the action to be effective. I am not interested in seeing nurses or social workers or any other professional group merely bang their heads against a stonewall. Our role as a professional group is to serve as a catalytic agent, galvanizing other stronger groups into positions of leadership rather than trying to spearhead social action ourselves.

In some communities, I am told, there has been confusion concerning the respective roles of the

professional organization of nurses and the local community Health Council. It is true that these two organizations share certain common objectives. To cite a single illustration, both are interested in raising standards. But to have common objectives means, or should mean, cooperation—not competition.

Take this question of standards, for example. Health Councils are usually interested in agency standards—how the agency is administered and how its program gears into the total needs and the existing resources of the community. Professional organizations are more likely to be interested in the content of professional practice—that is, the standards of skill applied in specific treatment situations. If the line between these and other mutual interests sometimes is blurred, it need not be a matter for serious concern. After all, only two organizations are concerned and the leaders in each are usually identified with both groups—that is, the organization of the Health Council in many places includes at least one professional nurse and many of the members of the ANA are organically related to the Health Council, are delegates to the Council, serve on various Council committees or participate in other ways in the Council program. When only two organizations are involved and when there are so many close interrelationships between them, it would seem to be a very simple matter to correlate their activities so that they would supplement rather than duplicate one another. Actually I think that is exactly what happens in most communities, and, if there is any community in which this has left either organization with less than enough to do, I haven't heard about it.

Because there is a considerable range of activities in which a professional organization may engage, most local groups, such as our District Nurses' Associations, need to develop criteria to guide us in selecting the areas in which we will try to be effective in any given year. No doubt various sets of criteria can be developed for this purpose. In many districts I think the following will usually be included: (1) The priorities suggested by the national office. Usually local groups want to participate in any study or in any activity to which all districts throughout the country are contributing; (2) urgency: some problems may deserve priority over others; (3) current local interests and attitudes: at certain times something happens to alert a community to a certain problem or a certain need and the climate of opinion thus becomes favorable for working on that problem; (4) available talent: a district program always has to be tailored to some extent to fit the capacities of those who can be persuaded to work on it. No doubt other criteria may be as important in some places as those I have mentioned. It is the task of the local district, usually through its executive committee or through a special committee created for the purpose to develop and apply criteria and to terminate with a suggested program suited to the needs and resources of the district.

Sometimes I have heard nurses ask this question: "How does our professional organization benefit me and the community in which I live?" I answer that question as I did at the outset: "It is not the primary purpose of a professional organization to benefit you or me as individuals. Actually it does benefit us as individuals in several ways—for example, in improving employment practices and in helping to enhance public respect for the profession. It also benefits the community. Nursing is an important—in fact, an essential—function. If it were suddenly all abolished, life, in many of our communities would quickly be precipitated into chaos. Hence, the community benefits from the professional association, because any improvement in any essential service is obviously of advantage to the community.

But, as I have said, the primary purpose of the professional association is not to benefit you and me as individuals, nor is it the primary purpose to benefit the community in which we live. The primary purpose of a professional organization is to strive for improved service for those who need the kinds of help the professional practitioner seeks to give. The longer history of the older professions seems to me to prove that, if the primacy of this purpose is sacrificed, the essential attribute of professional functioning is lost and practice becomes merely a craft by means of which one earns a living.

CULTURAL BELIEFS AND PRACTICES OF THE CHILDBEARING PERIOD AND THEIR IMPLICATIONS FOR NURSING PRACTICE (Continued)

Part III. Filipino Beliefs and Practices

Interviews by public health nurses with 37 rural and 7 urban Filipino families in Hawaii brought out the following present-day beliefs associated with childbearing:

In the rural group these beliefs regarding sex determination still exist: if the expectant mother gets up to walk and steps first on the right foot, or if the husband gets up on the right side after intercourse, a boy is expected. A fast fetal pulse rate, or heavy pigmentation, "mask of pregnancy" and prominently pointed abdomen on the mother's part mean a boy. When a mother craves long egg-

plant she will have a boy; craving for sweets and flowers means a girl.

Belief in evil spirits persists. Still believed are: a pregnant woman should avoid funerals and graveyards as spirits of the dead may harm the baby. Pregnant women should not go out at night. If this is necessary, wearing the hair long, covering the head or carrying a knife may ward off the spirits. A few believe smelly leaves should be carried to mask the odor of the baby.

Individuals believe in staying indoors on Good Friday, throwing rice on entering the hospital for delivery, and avoidance of making the sign of the cross by walking over a broom or letting string or wires cross. If the latter occurs, a "palina," a charcoal fire to which chicken feathers and cat and dog whiskers have been added, should be made. This drives off the spirits.

The baby's personal condition may be affected, some women said, by these factors: Unsatisfied food cravings may cause birthmarks. A crippled child may result if parents, during the pregnancy period, laugh at or criticize deformed people. If a mother looks at ducks or turtles, plays with a cat or eats ginger roots during pregnancy, her child may have webbed toes and fingers. Cleft lip and palate may result if the expectant mother eats cracked foods (eggs with a cracked shell or fruit with broken skin), sits on a coconut, or blows on a fire. Massage and manipulation of the baby's position are still thought beneficial, but massage of the abdomen is thought to force the baby's thumb into the cleft.

Actual birth process is said to be affected by varying practices. Beliefs include the old idea that eating tentacled fish like octopus or squid would hold back the baby's head. A few women fear auto riding will cause breech or miscarriage. Walking is designated as good exercise and general restrictions include only strenuous physical activity and attending funerals. About half the group believe that too much rest or sleep during pregnancy causes a difficult delivery and too much sleep is thought a cause of beri-beri and a resulting over-sized baby.

Taboos still followed are those against sitting in doorways, said to cause difficult birth, and walking over vines or ropes, said to delay birth or cause cord strangulation. A few women believe that dental care in pregnancy may cause premature birth and that frequent intercourse up to delivery will facilitate labor.

Present generation women show much concern about the lochial discharge. Many want a tight rice binder; used to prevent the blood from going to the head. Some favor massage to "squeeze out blood and prevent headaches." A few either avoid baths or shampoos for a month after delivery or avoid cold baths and cold drinks to prevent "curdling" of the blood. Eating aku, opelu and sour foods is said to stop the lochia. Fear is shown that if the lochia stopped the mother may "go crazy."

Individual women believe that standing so a woman's skirt is over the smoke of a palina will increase the lochial discharge, eating a ground-up earthworm will give strength for delivery, and stepping from the confinement bed to an iron plate will give the mother mental stability and a "solid feeling." One woman wanted as her first drink after delivery a soup in which some pieces of the placenta had been put. This would make the next delivery easy, she explained.

After the baby's birth, certain practices are thought necessary for the mother's health. A few women will not read, nor have a night light in their bedroom, for fear of blindness. Many rural women think housework, travel and dancing should be restricted for three months after confinement although an equal number cut the time down to two to four weeks. Frequently mentioned are beliefs that wearing a binder low about the thighs in the first month will prevent taking large steps and prolapsing the womb, that application of herbs to the abdomen will prevent retroversion and infection, that use of massage will retrovert the uterus to prevent future pregnancy, and that a key or papaya flower lei will dry up the breast milk.

Care of the cord and placenta is still thought to affect the child's welfare. Tying the cords of children together to insure a close sibling relationship is still done. The baby is still sometimes given a drink into which ashes of his cord and the placenta have been sprinkled. This is said to save his life in illness, to prevent him from cutting himself and to avoid a curse laid upon him. A good many women feel the cord and placenta must be safely disposed of, usually by burial and sometimes with orange leaves, to ward off devils. If cord and placenta are mishandled, some believe, the baby may be sickly, or die, or someday become insane. A carry-over of an old belief is that if a mother eats green weeping papaya her child will be a "cry baby."

Almost all the present folkways are not harmful. Only the practice of extraversion done by unskilled people, and the "massage" immediately after delivery, may injure the maternal organism. The prejudice against "too much sleep or rest" merits consideration in case it prevents a mother from getting enough rest. Education in modern

methods of maternal care may be done better when traditional practices are understood, it was pointed out.

In a specific case, knowledge by nurses of cultural beliefs may mean greater peace of mind for the mother. The hospital nurse who consults with the mother about disposal of the placenta or the keeping of part of the umbilical cord may be doing a great deal to put her patient's mind at rest. (To be concluded)

A CODE FOR PROFESSIONAL NURSES

ADOPTED BY THE ANA HOUSE OF DELEGATES AT SAN FRANCISCO, MAY 1950

Professional nurses minister to the sick, assume responsibility for creating a physical, social and spiritual environment which will be conducive to recovery, and stress the prevention of illness and promotion of health by teaching and example. They render health service to the individual, the family, and the community and co-ordinate their services with members of other health professions involved in specific situations.

Service to mankind is the primary function of nurses and the reason for the existence of the nursing profession. Need for nursing service is universal. Professional nursing service is therefore unrestricted by considerations of nationality, race, creed, or color.

Inherent in the code is the fundamental concept that the nurse subscribes to the democratic values to which our country is committed.

With reference to the following statements, the profession recognizes that a professional code cannot cover in detail all the activities and relationships of nurses, some of which are conditioned by personal philosophies and beliefs.

1. The fundamental responsibility of the nurse is to conserve life and to promote health.

2. The professional nurse must not only be adequately prepared to practice, but can maintain professional status only by continued reading, study, observation, and investigation.

3. When a patient requires continuous nursing service, the nurse must remain with the patient until assured that adequate relief is available.

4. The religious beliefs of a patient must be respected.

5. Professional nurses hold in confidence all personal information entrusted to them.

6. A nurse recommends or gives medical treatment without medical orders only in emergencies and reports such action to a physician at the earliest possible moment.

7. The nurse is obligated to carry out the physician's orders intelligently, to avoid misunderstanding or inaccuracies by verifying orders, and to refuse to participate in unethical procedures.

8. The nurse sustains confidence in the physician and other members of the health team; incompetency or unethical conduct of associates in the health professions should be exposed, but only to the proper authority.

9. The nurse has an obligation to give conscientious service and in return is entitled to just remuneration.

10. A nurse accepts only such compensation as the contract, actual or implied, provides. A professional worker does not accept tips or bribes.

11. Professional nurses do not permit their names to be used in connection with testimonials in the advertisement of products.

12. The Golden Rule should guide the nurse in relationships with members of other professions and with nursing associates.

13. The nurse in private life adheres to standards of personal ethics which reflect credit upon the profession.

14. In personal conduct nurses should not knowingly disregard the accepted patterns of behavior of the community in which they live and work.

15. The nurse as a citizen understands and upholds the laws and as a professional worker is especially concerned with those laws which affect the practice of medicine and nursing.

16. A nurse should participate and share responsibility with other citizens and health professions in promoting efforts to meet the health needs of the public—local, state, national, and international.

17. A nurse recognizes and performs the duties of citizenship, such as voting and holding office when eligible; these duties include an appreciation of the social, economic, and political factors which develop a desirable pattern of living together in a community.

NATIONAL ACCREDITATION

The School of Nursing of the University of Hawaii which started in September 1952, has received temporary accreditation by the Department of Baccalaureate and Higher Degree Programs of the National League for Nursing. Application for full accreditation will be made immediately since the League Board of Review has indicated that they believe the School is ready. This School is one of the 100 degree programs in the United States for basic nursing which are accredited by the National League for Nursing.

Students in the University School of Nursing receive their medical and surgical clinical experience at Kuakini Hospital, pediatric at Children's Hospital, psychiatric and obstetric at Tripler Army Hospital and communicable diseases at Leahi Hospital.

Seventy-five students are enrolled in the first three years. September of 1955 starts the fourth year of the program. During the last year the students will receive their public health nursing experience with the Department of Health. Graduates in June 1956 will receive a Bachelor of Science degree in Nursing.

FINAL REPORT OF NURSING COMMISSION

The Commission on Nursing Education and Nursing Service which was appointed by the Governor in 1951 will be discontinued as of July 1, 1955.

During the first two years the Commission put into pamphlet form an evaluation of nursing needs based on a survey made in the Territory

by a Nursing Study Committee. The pamphlet was called "Nurse of Tomorrow." It was widely distributed locally and throughout the mainland. Requests were received from libraries, counselling services, universities and colleges. There was one request from a school in England.

Its second objective was the collecting of information on scholarships and loans available to students for nursing education here and on the mainland. Miss Gwenfread Allen collected and compiled this information into an informative booklet called "Financial Aid for Students in Nursing."

The 1953-1955 objective of the Commission was to conduct a survey of nursing functions. This was done through the services of the Hawaii Research Laboratory of the University of Hawaii. Dr. Douglas Yamamura, Associate Professor of Sociology, who directed the survey, made an initial pilot study in a Honolulu hospital. Five other Oahu hospitals are now in the process of being studied.

The hospitals which so graciously consented to co-operate in this survey are: Leahi, St. Francis, Kuakini, Ewa, Southshore and Wahiawa.

Dr. Yamamura and his staff have reported excellent co-operation and good understanding of the program from administration through each employee interviewed.

All of these activities have been made possible through the funds provided the Commission by legislative action.

A summary of this survey will be available in the late summer.

MYRTLE SCHATTENBURG, *Chairman*

HIGHLIGHTS FROM THE NATIONAL LEAGUE FOR NURSING BIENNIAL CONVENTION

VIRGINIA A. JONES, PRESIDENT
HAWAII LEAGUE FOR NURSING

The National League for Nursing held its Second Biennial Convention in St. Louis, May 2-6. A glance at the printed program reveals how significant is the title League for Nursing. Joint meetings were held with the members of the Conference of State Boards of Nurse Examiners. Reports were presented from the Army, Navy and Air Force Nurse Corps. There was a Round Table on the Public Health Service Commission for National Emergencies and one meeting for lay members of the National League. Speakers represented industry, federal agencies, public relations organizations, anthropologists, general education, the American Hospital Association, private health agencies, and counsellors, as well as nursing service and nursing education. All of these rallied round the theme "Good Nursing for a Growing Nation."

There are now 90 local Leagues of Nursing, in 45 states and two territories, which boast of 7,000 individual and 650 agency members. Throughout the meetings there were expressions of regret that so few public health nurses were joining the League since their help and cooperation is needed by both the nursing service and education groups. The National Headquarters staff was asked to promote the organization of regional conferences of state leagues so that education and research projects and facilities as well as consultant services could be more effectively shared. Hawaii will hear more of this later.

The compiled annual report of all state leagues of nursing shows that many states, like Hawaii, are having difficulties in getting a working organization, in clarifying functions, in getting time in busy days to carry on activities and in increasing membership. It shows also that in spite of these difficulties much has been accomplished.

Some reports which told of activities of special importance to our Education Committee were those which reported efforts of the State Boards of Nurse Examiners to adopt more flexible standards for curricula in schools of nursing. It was recommended that only a general framework of curriculum requirements be adopted so that schools would have opportunity to carry out their objectives in ways most effective in their individual situations. Over-all time requirements to include all learning experiences, both classroom and clinical, in any one clinical area, were recommended. Other general educational practices were advised, such as the adoption of a school calendar based on academic rather than calendar years with all students entering and finishing on set dates each year; a balanced distribution of instruction and clinical practice in each year of the program; make-up time to be determined only on the basis of student's needs for learning experiences; and the simplification of student's final records. It was emphasized that any school operating on educational standards will base all decisions on whether "it is good for students."

Two specific recommendations were made by the Committee on More Flexible Standards:

1. That by voluntary agreement among states a specific passing score on the licensing examination be accepted for interstate registration without presentation of applicant's final school record.
2. That studies be made of the correlation between state standards for accreditation and the performance of the graduates from the schools accredited under these standards.

One whole session was devoted to operating room nursing and preparation for it. Emphasis was placed on patient-centered ward classes with the student being given the opportunity to prepare the patient for surgery, assist in the surgical procedure and care of him following the operation rather than a block of isolated experience in the operating room. One speaker, an operating room supervisor, said, "The nursing student should not be expected to perform as a skilled O.R. nurse during the program but only as a learner under close supervision."

Although I did not attend as many meetings of the Division of Nursing Service as of the Division of Education, two things in the area of service were significant to me: (1) that an amazing variety of studies of the quality of nursing service were being made, and their findings implemented; (2) that Hawaii was significantly lacking in organized effort to define its needs in nursing service. The states which had made the most progress in the improvement of nursing care were those which had State Committees for the Improvement of Patient Care. Three special areas of concern of the League are nurse shortage, the use of the team, and care of the aged.

One of the high spots for me was in meeting and lunching with Thelma Akana Harrison, who now lives in St. Louis, Albertine Sinclair who is Director of Nursing Service in a state psychiatric hospital in Mississippi, Margery MacLachlan, Director of the School of Nursing at the University of Wisconsin and one of her faculty members Miriam Keller, Mildred McFerren, now Director of Nurses at Grace Hospital, Detroit, and Anne Fisher, now Nursing Consultant for United States Foreign Operations Administration in El Salvador. All of these people asked to be remembered to their friends in Hawaii with what seemed to be a twinge of homesickness.

Twelve hundred students attended meetings of the National Student Nurses' Association. Daisy Yee, a St. Francis Hospital School of Nursing affiliate at St. Mary's in St. Louis, represented Hawaii's Student Nurses' Association. Her picture with Agnes Ohlson, President of the American Nurses' Association, and Ruth Sleeper, President of the National League for Nursing, will soon appear in both *Nursing Outlook* and the *American Journal of Nursing*.

I wish I could share with you the enthusiasm and "lift" that attending the meeting gave me. You can be assured that Hawaii is more than holding her own among the states in nursing activities.

PUBLIC HEALTH NURSES' SECTION—NEWS

KAZUE McLAREN

Fifty-four members of the Oahu District Public Health Nurses' and Industrial Nurses' Sections attended a joint dinner meeting at the Y.M.C.A. on Atkinson Drive on May 12, 1955.

The highlight of the meeting was a role play with Mrs. Emilia Centeio as the PHN and Miss Darlene Kubota as the industrial nurse discussing a problem—diabetic employee with a multigravida wife who had no medical care. Much discussion followed on areas of referral to community agencies, employment health policies and how the PHNS and industrial nurses could utilize each other's services more effectively.

Entertainment was provided by the school nurses; Miss Y. S. Ha, University of Hawaii PHN student from Korea; and the PHNS. It was generally agreed that much benefit could be had by the groups meeting together and tentative plans are being made to hold joint meetings in September and November to further discuss areas of common problems.

* * *

The fact finding committee of the Public Health Section, NATH, met with Dr. Thomas Ige, Associate Professor of Economics and Business, University of Hawaii, on May 12, 1955, to discuss further plans of their investigation.

Stating that the PHNs have done a good job, he recommended that:

1. The committee recommend minimum and maximum wage level with annual increments.
2. The section plan how to effectuate the committee's recommendations in regard to salaries and minimum standards.

He concluded, "If you plan to make a bold stab, don't fiddle faddle."

BOOK REVIEWS

The Physiology of Man

By L. L. Langley and E. Cheraskin, 609 pp., 180 ills., Price $5.50, McGraw-Hill, 1954.

After a very brief introduction, the authors present the subject matter in five parts. The first eight chapters deal with the nervous system, including muscular movement; the next seven chapters are devoted to the circulatory system. These two subjects occupy more than one-half of the book. Four chapters on the respiratory system form Part III, which is followed by five chapters on the alimentary and excretory systems. The last six chapters are devoted to the endocrine system. Each chapter has a brief summary. Each part has short descriptions of the anatomy of the system or organs whose physiological mechanism is to be discussed, and is concluded with a chapter on integration, attempting to fit the mechanisms selected for discussion into an integrated functional pattern.

As stated by the authors, this book is dedicated to the proposition that learning can be fun. The straight forward and lucid style used by the writers, in addition to a slight "sauciness" seen in the illustrations, do prove to be good fun as well as pedagogically sound for beginners. In the time allotted for the study of human physi-

ology in the crowded curriculum for nurses (also in the so-called general education course) the authors' selective approach to the broad and complicated subject of human physiology as shown by their selected illustrative material instead of comprehensive coverage, including moot matters, should be useful. In a summer session the reviewer translated one or two of the eye catching illustrations into words and tried them on a drowsy group of fledgling nurses on a sultry July afternoon. The result was lightening as well as enlightening. The authors are to be congratulated on their success in making physiology a fascinating study.

This book is not adequate, however, as a hardy menu for the budding physiologists who also need to get an insight into the method of science. Basic facts alone, and dogmatic statements about them, at the expense of presenting different facets of a controversy is not a pedagogical way to introduce the students to the method of science as used in physiology and is less of a challenge.

In spite of the fear among literati that the younger generations are rapidly becoming cartoon-reading illiterates, an occasional telling illustration, of which this book is in good supply, which drives a point home can do no harm but a lot of mnemonic service. This does not, however, replace the need for learning to read and be able to interpret standard figures, such as histological pictures, physiological charts and mathematical graphs, etc.

For nursing students this is a very teachable textbook.

SIDNEY C. HSIAO
Associate Professor of Zoology
University of Hawaii

Ward Administration

By Deborah MacLurg Jensen, R.N., B.S., M.A., 335 pp., illustrated, Price $4.00, C. V. Mosby Company, 1952.

This very simply written book will be most helpful to young head nurses and will be a desirable text for classes in Ward Administration.

The author's coverage of the topic provides an opportunity for young nurses to gain an appreciation and knowledge of the factors basic to effective management, personnel administration and meeting the needs of patients—too many books have been written without due emphasis on meeting the needs of patients, so a student may not perceive the hospitalization of the incapacitated as an added adjustment.

This book should be in every nursing library.

CYNTHIA L. WOLFE, R.N.
Assistant Professor of Nursing
University of Hawaii

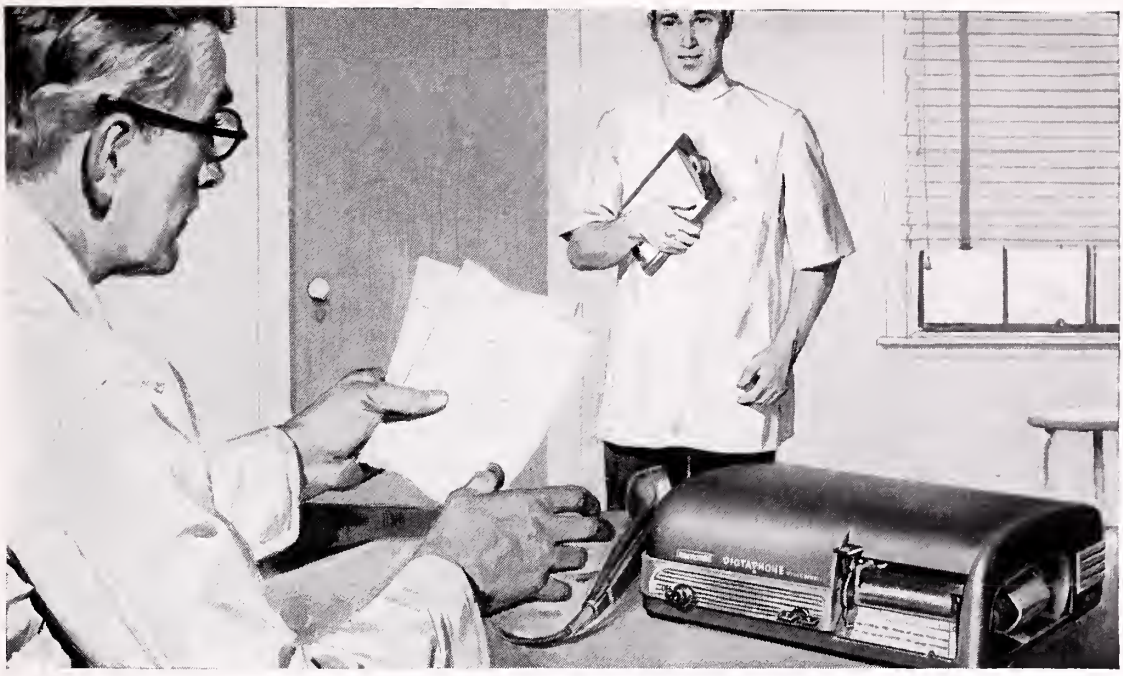


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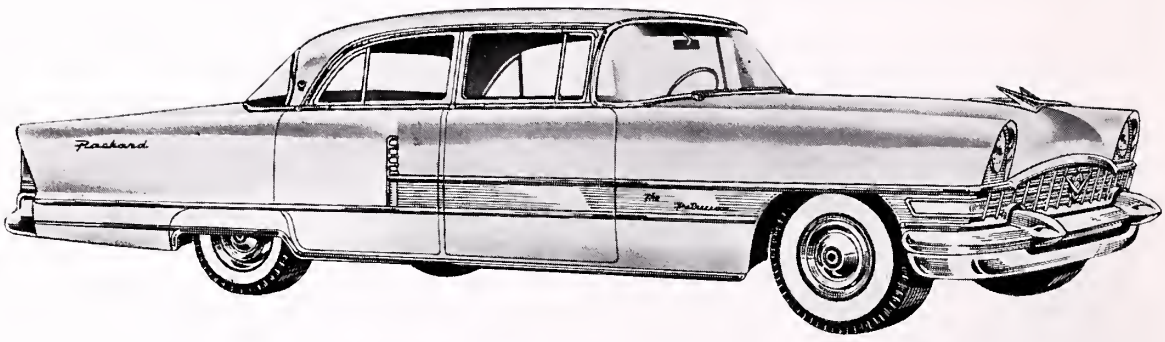
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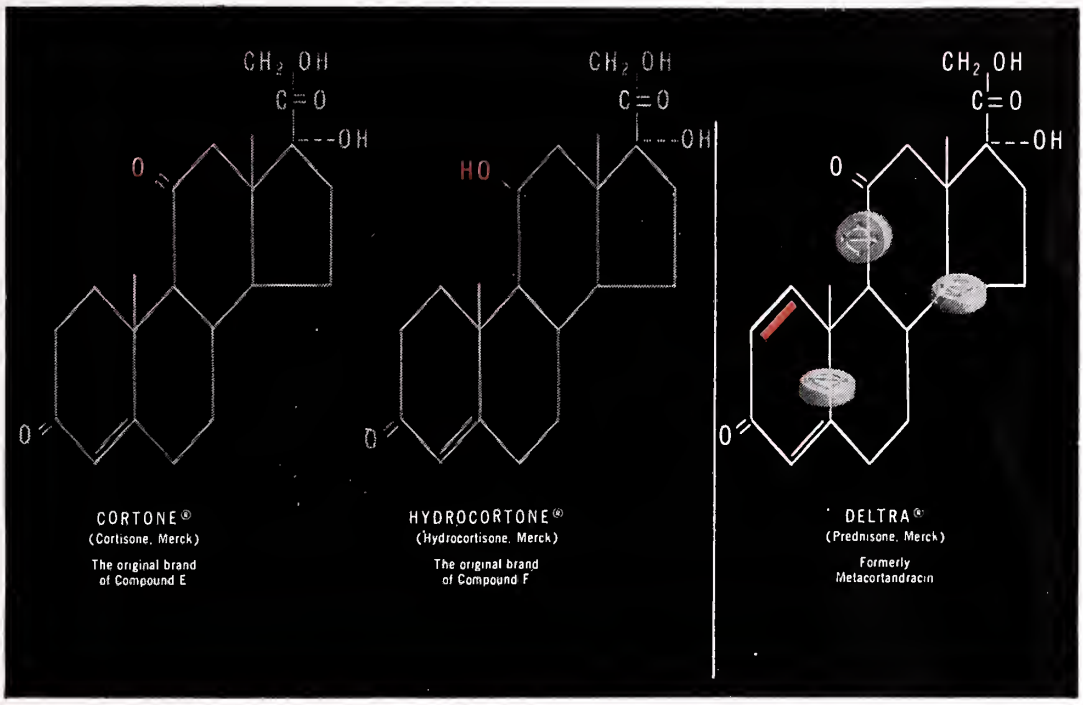
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AMA MEETING

(*Continued from page 511*)

standing job as delegate, both by representing us, and by serving the House of Delegates as a member of two reference committees. The latter of these jobs (acting on a reference committee) is not likely to be earned by many delegates serving only a single two-year term, even if they have attended two years as alternate; it is a personal tribute to Dr. Izumi that he has twice been asked to act in this capacity. This is primarily a service to the A.M.A.; it is of no direct value to the Hawaii Medical Association, except for the prestige it confers on us.

I am grateful for having had this valuable briefing, especially under Dr. Izumi, who is held in such esteem that he was able to have me invited to accompany him to all the functions normally attended only by delegates. It will be hard to succeed him, and impossible to replace him.

HARRY L. ARNOLD, JR., M.D.
Delegate-elect

MAUI COUNTY

(*Continued from page 514*)

suggestion met with general approval and will be followed through.

President Rockett read a letter from Dr. A. Y. Wong, Secretary of the Medical Staff of the Central Maui Memorial Hospital, dated April 14, 1955, and addressed to Dr. Harold Kushi, President of Maui County Medical Society. This letter asked that the County Medical Society investigate and dispose of matters pertaining to alleged office tonsillectomies.

The next order of business was the selection of three names to be submitted to Chairman Eddie Tam for his selection of one for the new Board of Trustees for the Central Maui Memorial Hospital.

By a show of hands it was demonstrated that the Society was in favor of having a medical man appointed to the Board. Also by the same method it was shown that the Society was in favor of having a physician who was not a member of the Central Maui Memorial Staff on the Board of Trustees.

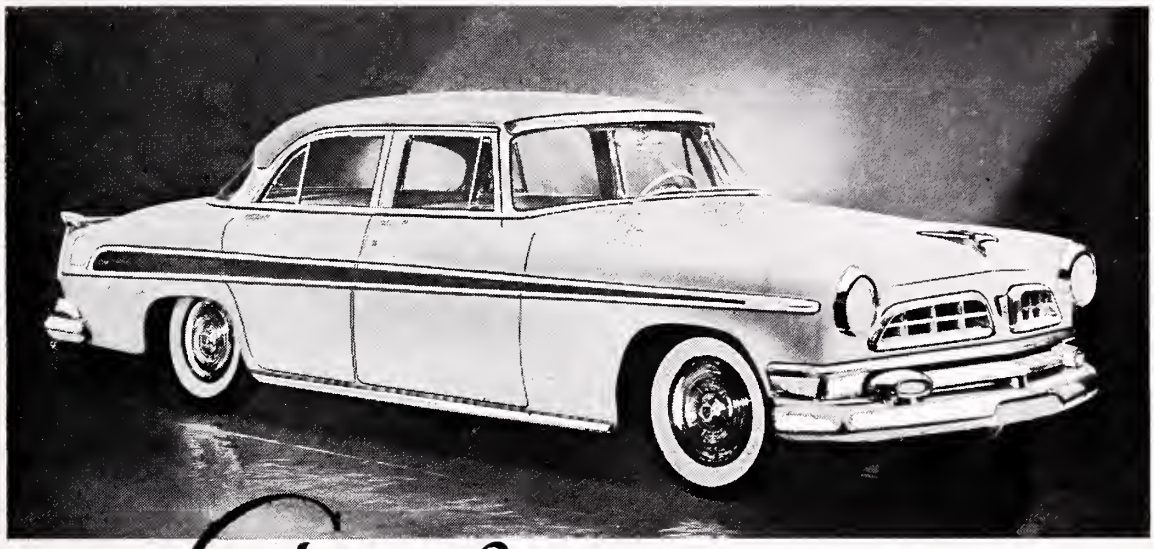
The Nominating Committee was instructed to meet within three weeks and submit the names of three people, any one of whom Mr. Tam could appoint to the Hospital Board of Trustees. The members of the Nominating Committee are: Doctors H. Kushi, Patterson, and Cole.

Dr. Ohata, as Chairman of the Committee appointed to recommend procurement of a pathologist, reported that after looking over qualifications of applicants Dr. Moran had been selected as the logical choice. He also advised that the recommendation of a radiologist was still under advisement until a later date.

(*Continued on page 557*)

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"Recently a statement was published by the Council on Foods and Nutrition of the American Medical Association calling attention to the extremely few cases of rickets today as compared with twenty years ago. It is the Vitamin D in combination with the calcium and phosphorus naturally occurring in milk which is chiefly responsible for all this modern miracle.

"The Council on Foods and Nutrition wishes to extend its thanks to you for making Vitamin D fortified milk available to the public, particularly the infants and children in your community. . . .

"Your desire to cooperate with the Council in its efforts to promote the intelligent use of Vitamin D Milk as an important public health measure is sincerely appreciated."

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MAUI COUNTY

(*Continued from page 554*)

Dr. Sanders reported on his observations made at the Hawaii Medical Association meetings. He gave a tongue lashing to the delegates for neglecting their duties at the annual meeting. Everyone was very repentant and probably made a resolution to not let such an incident happen again (until the next annual meeting).

It was moved by Dr. Sanders, seconded by Dr. Cole and passed that the treasurer pay the bill of $27.49 owed to the Duco Liquor Store.

Dr. Wong reported on action taken by H.M.S.A. against individuals filing fraudulent claims. He also reported on fees allowed by H.M.S.A. for use of radio isotopes.

JAMES F. FLEMING, M.D.
Secretary

BOOK REVIEWS

(*Continued from page 508*)

Reproductive System.

Prepared by Frank H. Netter, M.D., Edited by Ernst Oppenheimer, 286 pp., illustrated, Price $13.00, Ciba Pharmaceutical Products, Inc., 1954.

Everyone is familiar with the excellent and factual reproductions in color that have been drawn by Dr. Frank Netter and distributed during the past several years by the Ciba Pharmaceutical company. The collection concerning the reproductive system, male and female, has been compiled as volume two of the series and illustrates beautifully both the normal and pathologic anatomy.

In addition to those drawings (some 144) with which we are already familiar, Dr. Netter has added 89 new plates to depict more clearly the form and function of the involved organs. The sections concerning the breast and the diseases of pregnancy are particularly well done.

A pleasant surprise was the clear, concise commentary by an impressive list of collaborators. Another likeable feature is that the book is offered to the medical profession at the cost of publication and distribution; medical bookstores and others must adhere to this policy.

L. G. THOUIN, M.D.

Treatment of Acute Poliomyelitis.

By William A. Spencer, M.D., Second Edition, 134 pp., Price $3.75, Charles C. Thomas, 1954.

A valuable syllabus for physicians and instructors who desire a ready graphic and tabular reference. The subject is well covered, and is particularly fine on the respiratory complications of the disease.

This book should prove invaluable on any contagious disease ward, for it clearly outlines, step by step, the progress of poliomyelitis, how to anticipate complications, and how to handle them when they arise.

The source material was largely gathered from actual experience in the respiratory center at Houston, Texas. This is one of the eight big centers in the country that

(*Continued on page 558*)

METICORTEN
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BOOK REVIEWS

(*Continued from page 557*)

have done so much to further our knowledge in the care of the severely involved polio patient.

JOHN H. PEYTON, M.D.

Clinical Diagnosis.

By Elmer G. Wakefield, M.D., 1,611 pp., illustrated, Price $22.50, Appleton-Century-Crofts, Inc., 1955.

In this volume the author has produced an expanded text on physical diagnosis. The expansion has consisted of inclusion of laboratory and x-ray studies plus diagnostic tools. A lengthy bibliography at the end of each chapter is included. A chapter on treatment of poisonings is included.

The text gives a good brief summary of many clinical entities and offers an entree into more detailed literature. As this is a treatise on diagnosis, therapy isn't considered in any detail except in the case of poisonings.

RAYMOND M. DEHAY, M.D.

Fluoroscopy in Diagnostic Roentgenology.

By Otto Deutschberger, M.D., 771 pp., illustrated, Price $22.00, W. B. Saunders Company, 1955.

Fluoroscopy as it pertains to all possible facets of diagnostic medicine is a broad field. The author has tried to cover this extensive range with a resultant multitude of tiny paragraphs. They do prove that fluoroscopy can be used almost as extensively as radiography, albeit with a few limitations.

Nevertheless, a great deal of information has been gathered into one volume. This with the complete index and bibliography has produced an excellent reference book. For this purpose it is to be recommended. Some sections are quite complete, and it is a pleasure to have these points gathered together.

GEORGE W. HENRY, M.D.

ALSO RECEIVED

Semi-micro Organic Preparations.

By J. H. Wilkinson, B.Sc., Ph.D., F.R.I.C., 94 pp., Price $2.00, Charles C. Thomas, 1955.

Technique for small-scale analytic organic chemistry.

Tea—A Symposium on the Pharmacology and the Physiologic and Psychologic Effects of Tea.

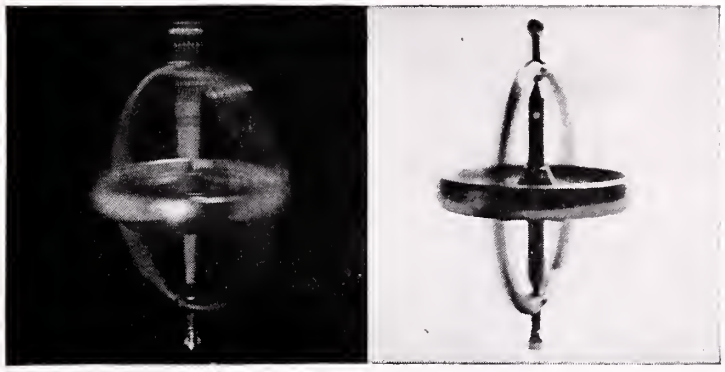
Edited by Henry J. Klaunberg, Ph.D., 64 pp., Price $1.00, The Biological Sciences Foundation, Ltd., 1955.

A symposium of 8 essays on various aspects of tea and its effects on the human body. The conclusions are in general highly complimentary.

(*Continued on page 561*)

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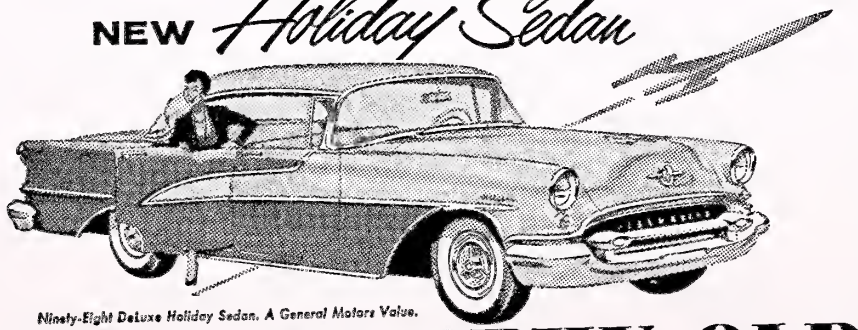
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BOOK REVIEWS

(*Continued from page 558*)

The Role of Humoral Agents in Nervous Activity.

By Bruno Minz, M.D., 230 pp., Price $7.75, Charles C. Thomas, 1955.

A valuable reference work.

Man's Ancestry.

By W. C. Osman Hill, M.D., 194 pp., illustrated, Price $4.25, Charles C. Thomas, 1955.

All about evolution, aimed at students of anthropology. Illustrated and interesting.

The Surgical Clinics of North America.

April 1955—Critical Emergencies, pp. 319-615, figs. 91-151, $18 per clinic year, cloth binding, $15 per clinic year, paper binding, W. B. Saunders Company, 1955.

A New York symposium on critical emergencies.

The Medical Clinics of North America.

March 1955—Rheumatic Diseases, pp. 323-619, figs. 71-123, $18 per clinic year, cloth binding; $15 per clinic year, paper binding, W. B. Saunders Company, 1955.

Nineteen clinics on various aspects of rheumatic fever, rheumatoid arthritis and gout. There is a chapter on Reiter's syndrome.

The Therapy of Skin Tuberculosis.

By Gustav Riehl, M.D., and Oswald Kopf, M.D., Translated and revised by Ernest A. Strakosch, M.D., 247 pp., Price $6.75, Charles C. Thomas, 1955.

Authoritative, complete, well-illustrated and indispensable to anyone required to treat this relatively rare (in America) disease. There are 284 references.

Management of Addictions.

Edited by Edward Podolsky, M.D., 413 pp., Price $7.50, Philosophical Library, 1955.

A collection of essays on different aspects of addiction, by which is said to be meant "the slavish devotion of oneself to a drug or a habit."

Ancient Therapeutic Arts.

By William Brockbank, M.D., 162 pp., illustrated, Price $5.00, Charles C. Thomas, 1955.

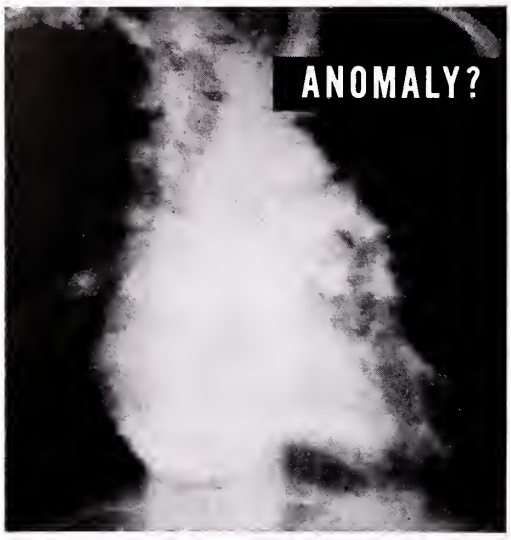
Enema administration, cupping and leeching, the seton and the issue, and intravenous injection of drugs, from the historical point of view, with a bibliography and scores of fascinating illustrations.

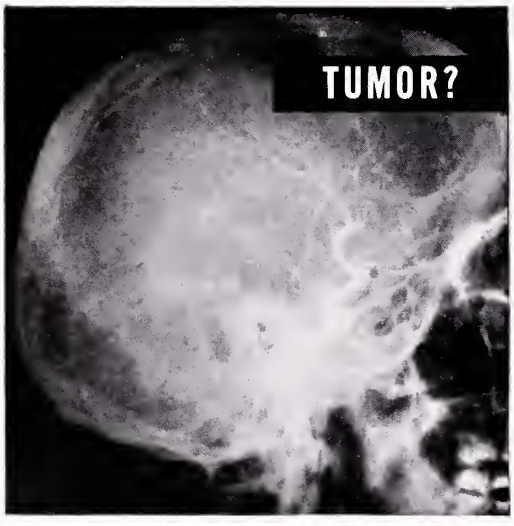
Practical Medical Mycology.

By Edmund L. Keeney, M.D., 145 pp., Price $4.50, Charles C. Thomas, 1955.

A compact presentation on mycology from an internist's point of view. Practical, concise, useful and authoritative.

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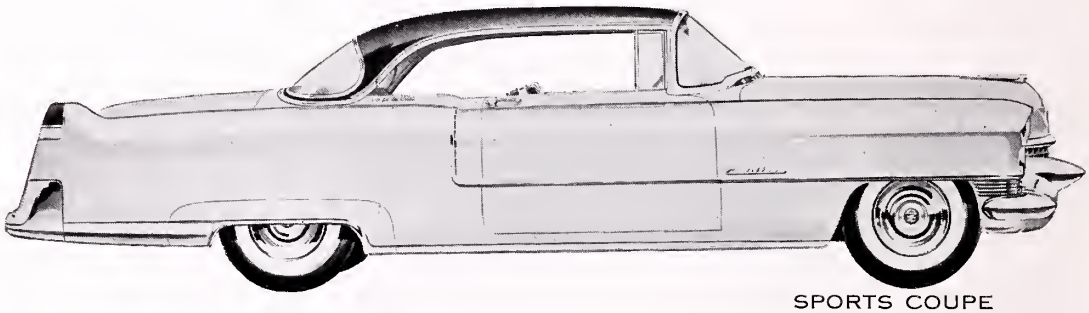


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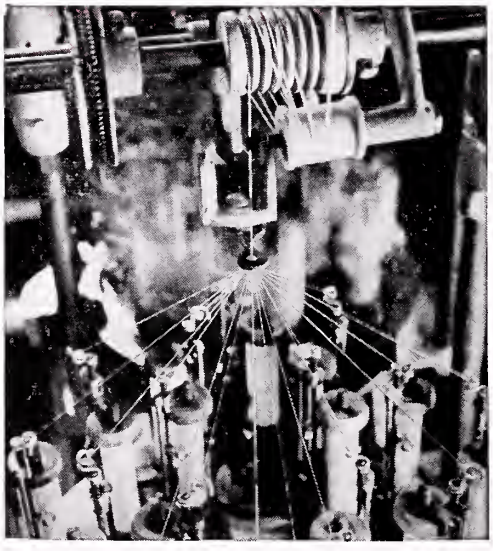
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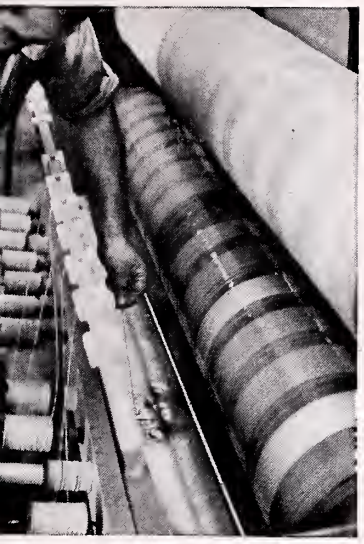
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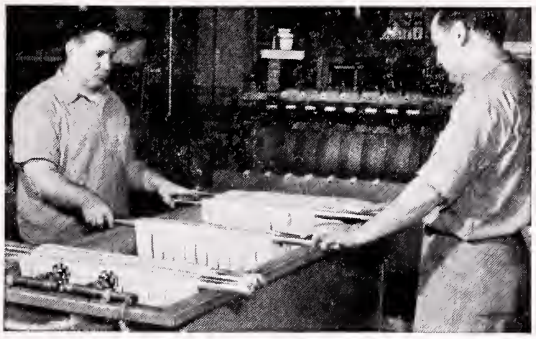
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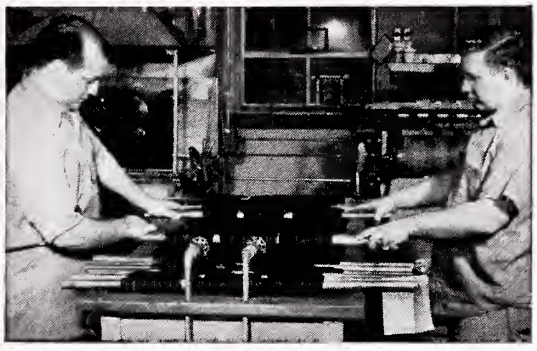


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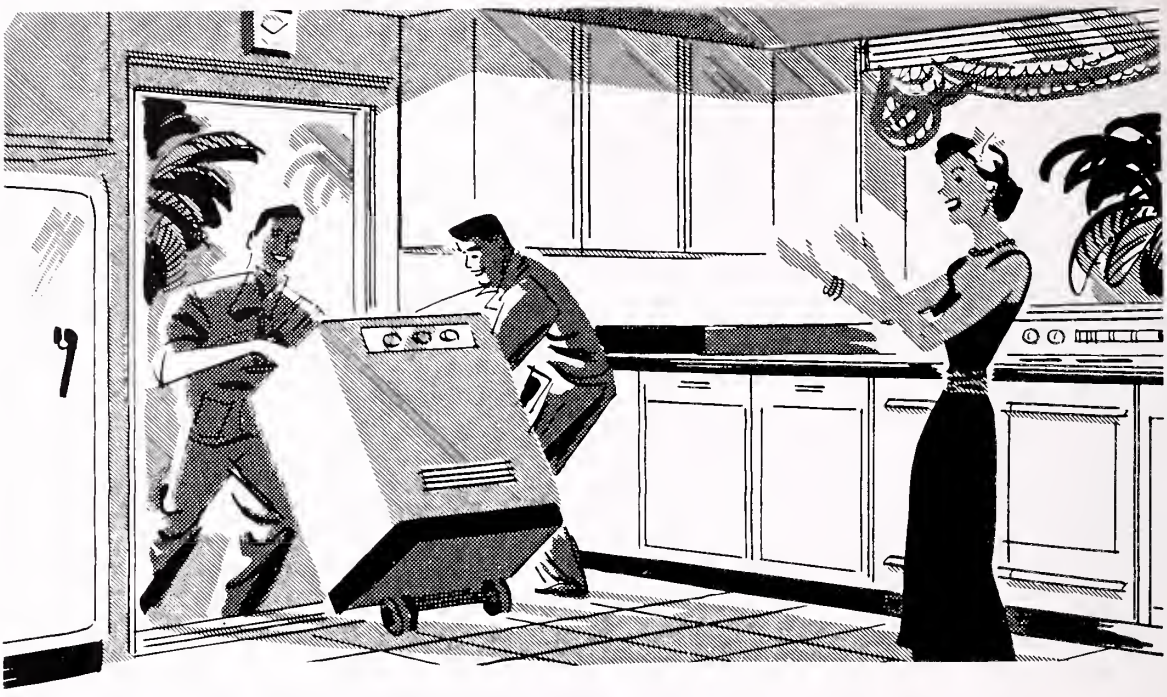
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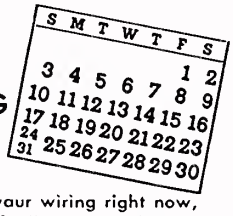
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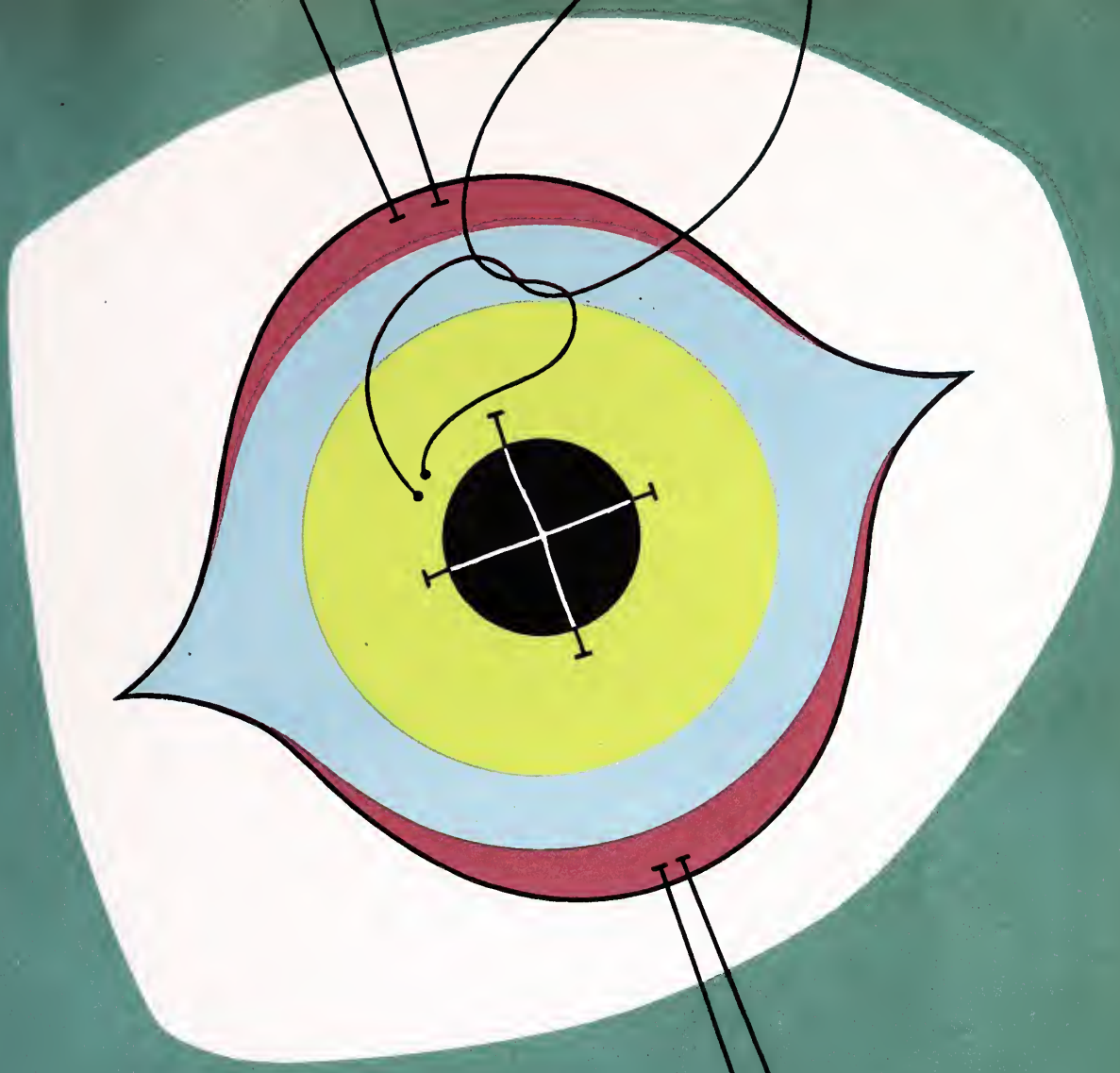


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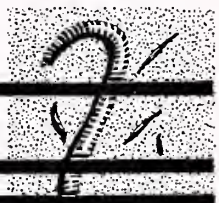
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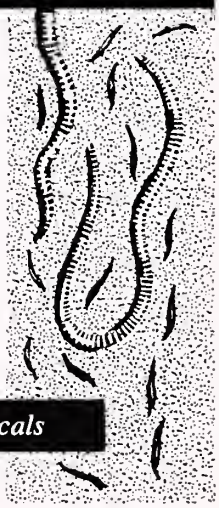
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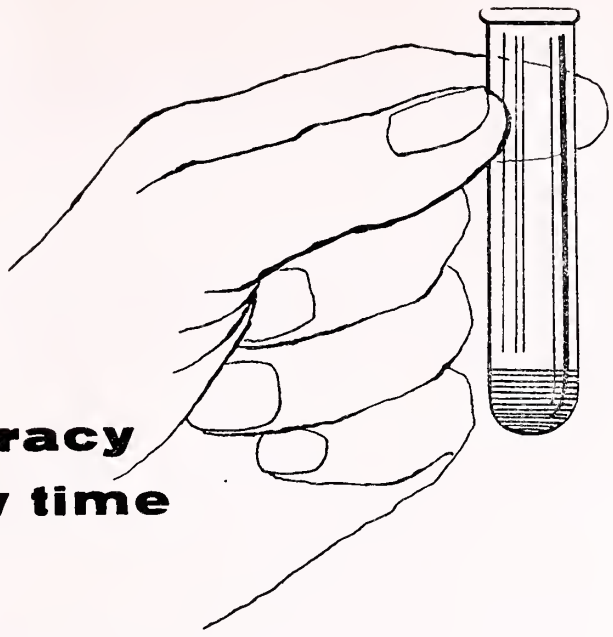
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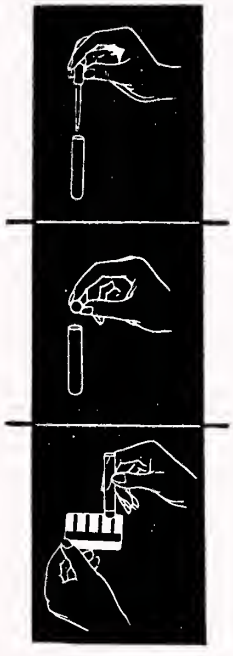
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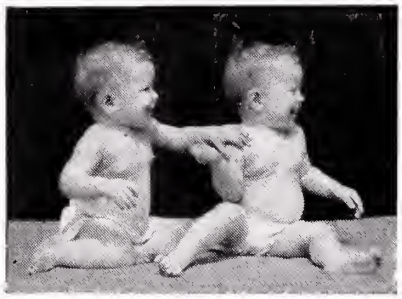
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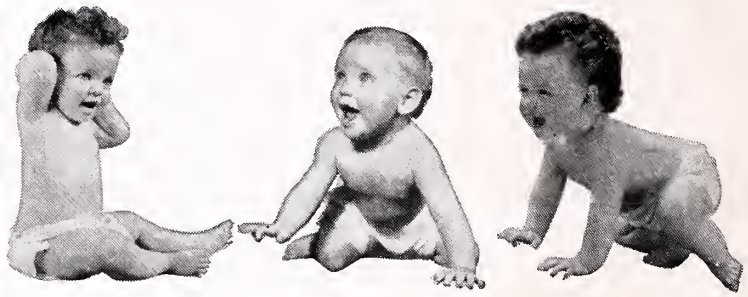


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(1) Jeans, P. C., in A. M. A. Handbook of Nutrition, ed. 2, Philadelphia, Blakiston, 1951, pp. 275-278.

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